Professional Services

This section contains payment policy information for professional services. Many of the policies contain information previously published in Provider Bulletins.

In addition to the policies outlined in this section, all providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules* (MARFS), Provider Bulletins and Provider Updates. If there are any services, procedures or text contained in the CPT® and HCPCS coding books that are in conflict with MARFS, the department's rules and policies take precedence (WAC 296-20-010). All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and self-insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

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This document is also on the department's Internet

http://www.lni.wa.gov/ClaimsIns/Providers/Billing/ FeeSched/2006/2006.asp.

Updates to this manual can be found on the department's web site

http://www.LNI.wa.gov/ClaimsIns/Providers/Billing /FeeSched/2006/Updates2006.asp

Updates to this manual are also announced on the Medical Provider e-News listserv. Individuals may join the listserv at

http://www.lni.wa.gov/Main/Listservs/Provider.asp.

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GENERAL INFORMATION

COVERED SERVICES

The department makes general policy decisions, called medical coverage decisions, to ensure quality of care and prompt treatment of workers. Medical coverage decisions include or exclude a specific health care service as a covered benefit.

Procedure codes listed as not covered in the fee schedules are not covered for the following reasons:

- 1. The treatment is not safe or effective; or is controversial, obsolete, investigational or experimental.
- 2. The procedure or service is generally not used to treat industrial injuries or occupational diseases.
- 3. The procedure or service is payable under another code.

The insurer may pay for procedures in the first two categories on a case-by-case basis. The health care provider must submit a written request and obtain approval from the insurer prior to performing any procedure in these categories. The written request must contain the reason for the request, the potential risks and expected benefits and the relationship to the accepted condition. The healthcare provider must provide any additional information about the procedure that may be requested by the insurer.

For more information on coverage decisions and covered services, refer to WAC 296-20 sections -01505, -02700 through -02850, -030, -03001, -03002 and -1102.

UNITS OF SERVICE

Payment for billing codes that do not specify a time increment or unit of measure is limited to one unit per day. For example, only one unit is payable for CPT® code 97022 regardless of how long the therapy lasts.

UNLISTED CODES

A covered service or procedure may be provided that does not have a specific code or payment level listed in the fee schedules. When reporting such a service, the appropriate unlisted procedure code may be used and a special report is required as supporting documentation. No additional payment is made for the supporting documentation. Refer to Chapter 296-20 WAC (including the definition section) and to the fee schedules for additional information.

PHYSICIAN ASSISTANTS

Physician assistants (PAs) must be certified to qualify for payment. PAs must have valid individual L&I provider account numbers to be paid for services.

PAs should use billing modifiers outlined in the RBRVS Payment Policies Section of MARFS. For example, to bill for Assistant at Surgery, the PA would use modifier –80, –81 or –82 as appropriate.

Consultations, impairment ratings and administrative or reporting services related to workers' compensation benefit determinations are not payable to physician assistants except as specified in RCW 51.28.021 and WAC 296-20-01502. Physician assistant services are paid to the supervising physician or employer at a maximum of 90% of the allowed fee.

Further information about physician assistant services and payment can be found in Provider Bulletin 99-04 and 04-09 and WAC 296-20-12501, WAC 296-20-01501 and WAC 296-20-01502.

WASHINGTON RBRVS PAYMENT SYSTEM AND POLICIES

The department uses the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. Services priced according to the RBRVS fee schedule have a fee schedule indicator of "R" in the Professional Services Fee Schedule.

BASIS FOR CALCULATING RBRVS PAYMENT LEVELS

RBRVS fee schedule allowances are based on relative value units (RVUs), geographic adjustment factors for Washington State and a conversion factor. The maximum fee for a procedure is obtained by multiplying the adjusted RVU by the conversion factor. The department's maximum fees are published as dollar values in the Professional Services Fee Schedule.

Under the Centers for Medicare and Medicaid Services (CMS) approach, RVUs are assigned to each procedure based on the resources required to perform the procedure, comprised of the work, practice expense and liability insurance (malpractice expense). A procedure with an RVU of 2 requires half the resources of a procedure with an RVU of 4.

Geographic adjustment factors are used to correct for differences in the cost of operating in different states and metropolitan areas producing an adjusted RVU described below.

The conversion factor is published in WAC 296-20-135. It has the same value for all services priced according to the RBRVS. The department may annually adjust the conversion factor by a process defined in WAC 296-20-132.

Three state agencies, Labor and Industries (L&I), Health Care Authority (HCA) and Department of Social and Health Services (DSHS), use a common set of RVUs and geographic adjustment factors for procedures, but use different conversion factors.

The primary source for the current RVUs is the 2005 Medicare Physician Fee Schedule Database (MPFSDB), which was published by (CMS) in the November 15, 2004 Federal Register. The Federal Register can be accessed online at http://www.gpoaccess.gov/index.html or can be purchased from the U.S. Government in hard copy, microfiche or disc formats. The Federal Register can be ordered from the following addresses:

Superintendent of Documents or http://bookstore.gpo.gov/index.html
PO Box 371954
Pittsburgh, PA 15250-7954

The state agencies geographically adjust the RVUs for each of these components based on the costs for Washington State. The Washington State geographic adjustment factors for July 1, 2005 are: 100.3% of the work component RVU, 101.7% of the practice expense RVU and 81.9% of the malpractice RVU.

To calculate the department's maximum fee for each procedure:

- 1. Multiply each RVU component by the corresponding geographic adjustment factor,
- 2. Sum the geographically adjusted RVU components and round the result to the nearest hundredth.
- 3. Multiply the rounded sum by the department's RBRVS conversion factor (published in WAC 296-20-135) and round to the nearest penny.

SITE OF SERVICE PAYMENT DIFFERENTIAL

The site of service differential is based on CMS's payment policy and establishes distinct maximum fees for services performed in facility and non-facility settings. The insurer will pay professional services at the RBRVS rates for facility and non-facility settings based on where the service was performed. Therefore, it is important to **include a valid two-digit place of service code on your bill**.

The department's maximum fees for facility and non-facility settings are published in the Professional Services Fee Schedule.

Services Paid at the RBRVS Rate for Facility Settings

When services are performed in a facility setting, the insurer makes two payments, one to the professional provider and another to the facility. The payment to the facility includes resource costs such as labor, medical supplies and medical equipment. To avoid duplicate payment of resource costs, these costs are excluded from the RBRVS rates for facility settings.

Professional services will be paid at the RBRVS rate for facility settings when the insurer also makes a payment to a facility. Therefore, services billed with the following place of service codes will be paid at the rate for facility settings:

Place of	
Service Code	Place of Service Description

05	Indian health service free-standing facility	
06	Indian health service provider-based facility	
07	Tribal 638 free-standing facility	
80	Tribal 638 provider-based facility	
21	Inpatient hospital	
22	Outpatient hospital	
23	Emergency room-hospital	
24	Ambulatory surgery center	
25	Birthing center	
26	Military treatment facility	
31	Skilled nursing facility	
34	Hospice	
41	Ambulance (land)	
42	Ambulance (air or water)	
51	Inpatient psychiatric facility	
52	Psychiatric facility partial hospitalization	
56	Psychiatric residential treatment center	
61	Comprehensive inpatient rehabilitation facility	
62	Comprehensive outpatient rehabilitation facility	
99	Other unlisted facility	
(none)	(Place of service code not supplied)	



Remember to include a valid two-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

Services Paid at the RBRVS Rate for Non-Facility Settings

When services are provided in non-facility settings, the professional provider typically bears the costs of labor, medical supplies and medical equipment. These costs are included in the RBRVS rate for non-facility settings.

Professional services will be paid at the RBRVS rate for non-facility settings when the insurer does not make a separate payment to a facility. Therefore, services billed with the following place of service codes will be paid at the rate for non-facility settings:

Place of Service Code

Place of Service Description

	• • • • • • • • • • • • • • • • • • •
01	Pharmacy
03	School
04	Homeless shelter
11	Office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
20	Urgent care facility
32	Nursing facility
33	Custodial care facility
49	Independent clinic
50	Federally qualified health center
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment center
57	Non-residential substance abuse treatment center
60	Mass immunization center
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Inpatient laboratory

Facilities will be paid at the RBRVS rate for non-facility settings when the insurer does not make a separate payment directly to the provider of the service.



Remember to include a valid two-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

EVALUATION AND MANAGEMENT SERVICES (E/M)

NEW AND ESTABLISHED PATIENT

The department uses the CPT® definitions of new and established patients.

If a patient presents with a work related condition and meets the definition of a new patient in a provider's practice, then the appropriate level of a new patient E/M should be billed.

If a patient presents with a work related condition and meets the definition of an established patient in a provider's practice, then the appropriate level of established patient E/M service should be billed, **even if the provider is treating a new work related condition for the first time.**

MEDICAL CARE IN THE HOME OR NURSING HOME

The department allows attending providers to charge for nursing facility services, domiciliary, rest home (e.g., boarding home), or custodial care services and home services. The attending provider (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

PROLONGED EVALUATION AND MANAGEMENT

Payment of prolonged E/M is allowed with a maximum of three hours per day per patient. These services are payable only when another E/M code is billed on the same day using the following CMS payment criteria:

CPT® Code	Other CPT® Code(s) Required on Same Day
-----------	---

99354	99201-99205, 99212-99215, 99241-99245 or 99324-99350
99355	99354 and one of the E/M codes required for 99354
99356	99221-99223, 99231-99233, 99251-99255, 99304-99310
99357	99356 and one of the E/M codes required for 99356

The time counted toward payment for prolonged E/M services includes only direct face-to-face contact between the provider and the patient (whether the service was continuous or not). Prolonged physician services without direct contact are bundled and are not payable in addition to other E/M codes.

A narrative report is required when billing for prolonged evaluation and management services. See Appendix H for additional information.

USING THE -25 MODIFIER

Modifier –25 must be appended to an E/M code when reported with another procedure on the same date of service. Modifier –25 must be reported in the following circumstances:

- Same patient, same day encounter at a separate visit; and
- Same physician or provider; and
- Patient condition required a "significant separately identifiable E/M service above and beyond the usual pre and post-op care" related with the procedure or service.

Example 1:

An injured worker comes into an osteopathic physician's office to be treated for back pain. After reviewing the history, conducting a review of body systems and performing a clinical examination the provider advises the worker that osteopathic manipulation is a therapeutic option for treatment for the condition.

The physician performs the manipulation during the office visit. Since a significant separately identifiable E/M service was performed at the same time as an unscheduled procedure, the physician may bill the appropriate CPT® code for the manipulation and the E/M code with the – 25 modifier for this office visit.

Example 2:

An injured worker arrives at a physician's office for a scheduled follow up visit for a work related injury. During the examination, the physician determines that the worker's condition requires a course of treatment that includes a trigger point injection at this time. The trigger point injection was not scheduled previously as part of the E&M visit.

The physician gives the injection during the visit. Since a significant separately identifiable procedure was performed at the time of the E/M service, the physician may bill the appropriate CPT® code for the injection and the E/M code with the –25 modifier for the same time and date of service.

Example 3:

An injured worker arrives at a physician's office in the morning for a scheduled follow up visit for a work related injury. That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen.

The provider sees the patient for a second office visit. Since the two visits were completely separate, both E/M services may be billed. The scheduled visit would be billed with the appropriate E/M code alone and the unscheduled visit would be billed with the appropriate E/M code with the –25 modifier.

TREATING TWO SEPARATE CONDITIONS/SPLIT BILLING POLICY

If the worker is treated for two separate conditions at the same visit, the charge for the service must be apportioned equally between the payers. If evaluation and treatment of the two injuries increases the complexity of the visit, a higher level E/M code might be billed. If this is the case, CPT® guidelines must be followed and the documentation must support the level of service billed. A physician would only be entitled to payment for more than one evaluation and management visit if there were two separate and distinct visits on the same day (see the Example 3 above).

Scheduling back-to-back appointments does not meet the criteria for using the -25 modifier.

Because of privacy laws separate chart notes and reports must be submitted when there are two different claims. The claims may be the result of injuries while working for two different employers and the employers only have the right to information about injuries they are responsible for.



List all workers' compensation claims treated in Box 11 of the CMS-1500 form when submitting paper bills to the department and in the remarks section when submitting electronic claims. The department will apportion charges equally to the claims.

If part of the visit is for a condition unrelated to an accepted L&I claim and part is for the accepted condition, providers must apportion their usual and customary charges equally between L&I and the other payer based on the level of service provided during the visit. In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer does not have the right to see information about an unrelated condition.

Example 1:

An injured worker comes into the office to be treated for a work related shoulder injury and a separate work related knee injury. The physician treats both work related injuries. The provider would bill one visit to the department listing both workers' compensation claims in Box 11 of the CMS-1500 form. The department will apportion charges equally to the claims.

Example 2:

An injured worker comes into the physician's office to be treated for work related injury (LNI or self-insured claim). During the examination, the injured worker mentions that he was in a car accident yesterday and now has neck pain. The physician treats the work related injury and the neck pain associated with the motor vehicle accident. The provider would bill 50% of his usual and customary fee to LNI or self-insured employer and 50% to the insurance company paying for the motor vehicle accident. The insurer would only be responsible for the portion related to the accepted work related injury.

PHYSICIAN STANDBY SERVICES

The insurer pays for physician standby services when all the following criteria are met:

- Another physician requested the standby service; and
- The standby service involves prolonged physician attendance without direct face-to-face patient contact; and
- The standby physician is not concurrently providing care or service to other patients during this period; and
- The standby service does not result in the standby physician's performance of a procedure subject to a "surgical package;" and
- Standby services of 30 minutes or more are provided.

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported. Round all fractions of a 30-minute unit downward.

Justification for the physician standby service must be documented and retained in the provider's office and submitted to the insurer for review upon request.

A narrative report is required when billing for physician standby services.

CASE MANAGEMENT SERVICES

Team Conferences

Team conferences may be payable when the attending provider, consultant or psychologist meets with an interdisciplinary team of health professionals, department staff, vocational rehabilitation counselors, nurse case managers, department medical consultants, self-insurer representatives or employers. Physical and occupational therapists and speech-language pathologists may be paid for attendance at a team conference when certain conditions are met. (See below) Documentation must include a goal-oriented, time-limited treatment plan covering medical, surgical, vocational or return to work activities, or objective measures of function that allow a determination as to whether a previously created plan is effective in returning the injured worker to an appropriate level of function.

Physical and Occupational Therapists

Physical and occupational therapists and speech-language pathologists may be paid for attendance at a team conference only when the conference is authorized in advance by the Medical Director/Associate Medical Director at L&I or the self-insured employer.

To be authorized all of the following criteria must be met:

- There is a moderate to high probability of severe, prolonged functional impairment that may be addressed with the development of a multi-disciplinary approach to the plan of care: and
- The need for a conference exceeds routine correspondence/communication that is expected among healthcare/vocational providers; and
- The worker is not participating in a program in which payment for conference is already included in the program payment (e.g., head injury program, pain clinic, work hardening); and
- Three or more disciplines/specialties need to participate, including PT, OT or Speech.

To be paid for the conference the therapists must do the following:

- Bill using CPT® code 99361 or 99362
- Bill on a CMS-1500 form
- Each individual provider seeking payment must provide a separate report of the conference; joint reports are not allowed. The conference report must include:
 - Evaluation of the effectiveness of the previous therapy plan; and
 - New goal-oriented, time-limited treatment plan or objective measures of function that address the return to work process.

Note: Providers in a hospital setting may only be paid if the services are billed with an individual provider number on a CMS-1500 bill form.

Telephone Calls

Telephone calls are payable only when personally made by the attending provider, consultant or psychologist. These services are payable when discussing or coordinating care or treatment with the injured worker, department staff, vocational rehabilitation counselors, nurse case managers, department medical consultants, self-insurer representatives or employers. Telephone calls for authorization, resolution of billing issues or ordering prescriptions are not payable.

Documentation Requirements

Documentation for case management services must include:

- The date, and
- The participants and their titles, and
- The length of the call or visit, and
- The nature of the call or visit, and
- All medical, vocational or return to work decisions made.

Psychiatrists and clinical psychologists may only bill for case management services when also providing consultation or evaluation.

PHYSICIAN CARE PLAN OVERSIGHT

The insurer allows separate payment for physician care plan oversight services (CPT® codes 99375, 99378 and 99380). Payment is limited to one per attending provider, per patient, per 30-day period. Care plan services (CPT® codes 99374, 99377 and 99379) of less than 30 minutes within a 30-day period are considered part of E/M services and are not separately payable.

Payment for care plan oversight to a physician providing post surgical care during the postoperative period will be made only if the care plan oversight is documented as unrelated to the surgery, and modifier –24 is used. The attending provider (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

TELECONSULTATIONS

The department has adopted a modified version of CMS's policy on teleconsultations. Teleconsultations require an interactive telecommunication system, consisting of special audio and video equipment that permits real-time consultation between the patient and consultant.

Coverage of Teleconsultations

Teleconsultations are <u>covered</u> in the same manner as face-to-face consultations (refer to WACs 296-20-045 and -051), but in addition, **all** of the following conditions must be met:

- The **consultant** must be a doctor as described in WAC 296-20-01002 or a PhD Clinical Psychologist. A consulting DC must be an approved consultant with the department; and
- The referring provider must be one of the following: MD, DO, ND, DPM, OD, DMD, DDS, DC, ARNP, PA or PhD Clinical Psychologist; and
- The patient must be present at the time of the consultation; and
- The examination of the patient must be under the control of the consultant; and
- Interactive audio and video telecommunications must be used allowing real time communication between the patient and the consultant; and
- The consultant must submit a written report documenting this service to the referring provider, and must send a copy to the insurer; and
- A referring provider who is not the attending must consult with the attending provider before making the referral.

Payment of Teleconsultations

Consultants

Teleconsultations are paid in the same manner as face-to-face consultations. The insurers will pay according to the following criteria:

- Consultants must append a "GT" modifier to one of the appropriate services listed in the table below.
- No separate payment will be made for the review and interpretation of the patient's medical records and/or the required report that must be submitted to the referring provider and to the insurer.

The Consultant May Bill These Services:

Consultation Codes
Office or other Outpatient Visits
Psychiatric Intake and Assessment
Individual Psychotherapy
Pharmacologic Management
End Stage Renal Disease (ESRD) Services

Originating Facility

The insurer will pay an originating site facility fee for the use of the telecommunications equipment. Bill for these services with HCPCS code:

Q3014\$31.30

A charge for a professional service by the referring provider is payable only if there is a separately identifiable professional service provided on the same day as the telehealth service. Documentation for both must be clearly and separately identified in the medical record.

Telemedicine Services Not Covered

Procedures and services not covered include:

- "Store and Forward" technology, asynchronous transmission of medical information to be reviewed by the consultant at a later time.
- Email, telephonic consultations and facsimile transmissions.
- Installation or maintenance of telecommunication equipment or systems.
- Home health monitoring.
- Telehealth transmission, per minute (HCPCS code T1014).
- Online medical evaluation, per encounter.

END STAGE RENAL DISEASE (ESRD)

The department follows CMS's policy regarding the use of E/M services along with dialysis services. E/M services (CPT® codes 99231-99233 and 99307-99310) are not payable on the same date as hospital inpatient dialysis (CPT® codes 90935, 90937, 90945 and 90947). These E/M services are bundled in the dialysis service.

Separate billing and payment for an initial hospital visit (CPT® codes 99221-99223), an initial inpatient consultation (CPT® codes 99251-99255) and a hospital discharge service (CPT® code 99238 or 99239) will be allowed when billed on the same date as an inpatient dialysis service.

SURGERY SERVICES

GLOBAL SURGERY POLICY

Many surgeries have a follow-up period during which charges for normal postoperative care are bundled into the global surgery fee. The global surgery follow-up period for each surgery is listed in the "Fol-Up" column in the Professional Services Fee Schedule.

Services and Supplies Included in the Global Surgery Policy

The following services and supplies are included in the global surgery follow-up period and are considered bundled into the surgical fee:

- The operation itself.
- Preoperative visits, in or out of the hospital, beginning on the day before the surgery.
- Services by the primary surgeon, in or out of the hospital, during the postoperative period.
- Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints; insertion, irrigation and removal of urinary catheters, cast room charges, routine peripheral IV lines, nasogastric and rectal tubes; and change and removal of tracheostomy tubes. Casting materials are not part of the global surgery policy and are paid separately.
- Additional medical or surgical services required because of complications that do not require additional operating room procedures.

How to Apply the Follow-Up Period

The follow-up period applies to **any provider** who participated in the surgical procedure. These providers include:

- Surgeon or physician who performs any component of the surgery (e.g., the pre, intra, and/or postoperative care of the patient; identified by modifiers –56, –54 and –55)
- Assistant surgeon (identified by modifiers –80, –81 and –82)
- Two surgeons (identified by modifier –62)
- Team surgeons (identified by modifier –66)
- Anesthesiologists and CRNAs

The follow-up period always applies to the following CPT $^{\circ}$ codes, unless modifier -22, -24, -25, -57, -58, -78 or -79 is appropriately used:

E/M Codes		Ophthalmological Codes
99211-99215	99315-99318	92012-92014
99218-99220	99334-99337	
99231-99239	99347-99350	
99291-99292	99304-99310	

Professional inpatient services (CPT® codes 99211-99223) are only payable during the follow-up period if they are performed on an emergency basis (i.e., they are not payable for scheduled hospital admissions).

Codes that are considered bundled are **not payable** during the global surgery follow-up period.

Services and Supplies Not Included in the Global Surgery Policy

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery.
- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care.
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complication of the surgery.
- Treatment for the underlying condition or an added course of treatment which is not part of the normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatment for complications (A new postoperative period begins with the subsequent procedure.)
- Treatment for postoperative complications which requires a return trip to the operating room (OR).
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Immunotherapy management for organ transplants.
- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

PRE, INTRA, OR POSTOPERATIVE SERVICES

The insurer will allow separate payment when different physicians or providers perform the preoperative, intraoperative or postoperative components of the surgery. The appropriate modifiers (–54, –55 or –56) must be used. The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule.

If different providers perform different components of the surgery (pre, intra, or postoperative care), the global surgery policy applies to each provider. For example, if the surgeon performing the operation transfers the patient to another physician for the postoperative care, the same global surgery policy, including the restrictions in the follow-up day period, applies to both physicians.

MINOR SURGICAL PROCEDURES

For minor surgical procedures, the department follows CMS's policy to not allow payment for an E/M office visit during the global period unless:

- A documented, unrelated service is furnished during the postoperative period and modifier
 –24 is used, or
- The practitioner who performs the procedure is seeing the patient for the first time, in which case an initial new patient E/M service can be billed. This is considered a significant, separately identifiable service and modifier –25 must be used. Appropriate documentation must be made in the chart describing the E/M service.

Modifier –57, decision for surgery, is not payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation is not paid in addition to the procedure.

Modifier –57 is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

STANDARD MULTIPLE SURGERY POLICY

When multiple surgeries are performed on the same patient at the same operative session or on the same day, the total payment equals the sum of:

100% of the global fee for the procedure or procedure group with the highest value, according to the fee schedule.

50% of the global fee for the **second through fifth procedures** with the next highest values, according to the fee schedule.

Procedures in excess of five require submission of documentation and individual review to determine payment amount.

When different types of surgical procedures are performed on the same patient on the same day for accepted conditions, the payment policies will always be applied in the following sequence:

- Multiple endoscopy procedures for endoscopy procedures.
- Other modifier policies.
- Standard multiple surgery policy.

When the same surgical procedure is performed on multiple levels, each level must be billed as a separate line item. See the Bilateral Procedures Policy for additional instructions on billing bilateral procedures.

BILATERAL PROCEDURES POLICY

Bilateral surgeries should be billed as two line items. Modifier –50 should be applied to the second line item. When billing for bilateral surgeries, the two line items should be treated as one procedure. The second line item is paid at the lesser of the billed charge or 50% of the fee schedule maximum. Bilateral procedures are considered one procedure when determining the highest valued procedure before applying multiple surgery rules.



Check the Professional Services Fee Schedule to see if modifier –50 is valid with the procedure performed.

Example: Bilateral Procedure

Line Item	CPT [®] Code/Modifier	Maximum Payment (non-facility setting)	Bilateral Policy Applied	Allowed Amount
1	64721	\$ 563.89		\$ 563.89 ⁽¹⁾
2	64721-50	\$ 563.89	\$ 281.95 ⁽²⁾	\$ 281.95
Total Allowed Amount in Non-Facility Setting:			\$ 845.84 ⁽³⁾	

- (1) Allowed amount for the highest valued procedure is the fee schedule maximum.
- (2) When applying the bilateral payment policy, the two line items will be treated as one procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
- (3) Represents total allowable amount.

Example: Bilateral Procedure and Multiple Procedures

Line Item	CPT [®] Code/Mod	Max Payment (non-fac setting)	Bilateral Applied	Multiple Applied	Allowed Amount
1	63042	\$ 1769.20			\$ 1769.20 ⁽¹⁾
2	63042-50	\$ 1769.20	\$ 884.60 ⁽²⁾		\$ 884.60
					subtotal \$ 2653.80 ⁽³⁾
3	22612-51	\$ 2130.30		\$ 1065.15 ⁽⁴⁾	\$ 1065.15
	Total Allowed	d Amount in Non-Fac		\$ 3718.95 ⁽⁵⁾	

- (1) Allowed amount for the highest valued procedure is the fee schedule maximum.
- (2) When applying the bilateral payment policy, the two line items will be treated as one procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
- (3) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.
- (4) The third line item billed with modifier –51 is paid at 50% of the maximum payment.
- (5) Represents total allowable amount.

ENDOSCOPY PROCEDURES POLICY

For the purpose of these payment policies, the term, "endoscopy" will be used to refer to any invasive procedure performed with the use of a fiberoptic scope or other similar instrument.

Payment is not allowed for an E/M office visit on the same day as a diagnostic or surgical endoscopic procedure unless a documented, separately identifiable service is provided and modifier –25 is used.

Endoscopy procedures are grouped into clinically related "families." Each endoscopy family contains a "base" procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an endoscopy family is listed in the "Endo Base" column in the Professional Services Fee Schedule. Base procedures and their family members are also identified in **Appendix A**, "Endoscopy Families."

When multiple endoscopy procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

- 1. Maximum payment for the endoscopy procedure with the highest dollar value listed in the fee schedule is 100% of the fee schedule value.
- For subsequent endoscopy procedures, maximum payment is calculated by subtracting the fee schedule maximum for the base procedure from the fee schedule maximum for the endoscopy family member.
- 3. When the fee schedule maximum for a family member is less than that of the base code, there will be no add-on provided and no reduction in payment. Consider the portion of payment for this family member equal to \$0.00 (see example 2).
- 4. No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an "endoscopic group." If more than one endoscopic group or other non-endoscopy procedure is billed for the same patient on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see example 3).

Multiple endoscopies that are not related (e.g., each is a separate and unrelated procedure) are priced as follows:

- 1. 100% for each unrelated procedure, then
- 2. Apply the standard multiple surgery policy

Example 1: Two Endoscopy Procedures in the Same Family

Line Item	CPT [®] Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	29870	\$ 585.03	\$ 000.00 (2)	
1	29874	\$ 770.47	\$ 185.44 ⁽⁴⁾	\$ 185.44 ⁽⁵⁾
2	29880	\$ 937.46	\$ 937.46 ⁽³⁾	\$ 937.46 ⁽⁵⁾
		\$ 1122.90 ⁽⁶⁾		

- (1) Base code listed is for reference only (not included on bill form).
- (2) Payment is not allowed for a base code when a family member is billed.
- (3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
- (4) Allowed amount for other procedures in the same endoscopy family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.
- (5) Amount allowed under the endoscopy policy.
- (6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy does not apply because only one family of endoscopic procedures was billed.

Example 2: Endoscopy Family Member with Fee Less than Base Procedure

Line Item	CPT [®] Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	43235	\$ 426.17		
1	43241	\$ 211.46	\$ 000.00 (2)	
2	43251	\$ 296.04	\$ 296.04 ⁽³⁾	\$ 296.04 ⁽⁴⁾
Total Allowed Amount in Non-Facility Setting:			\$ 296.04 ⁽⁵⁾	

- (1) Base code listed is for reference only (not included on bill form).
- (2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
- (3) When the fee schedule maximum for a code in an endoscopy family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to \$0.00.
- (4) Allowed amount under the endoscopy policy.
- (5) Represents total allowed amount. Standard multiple surgery policy does not apply because only one endoscopic group was billed.

Example 3: Two Surgical Procedures Billed with an Endoscopic Group

Line Item	CPT [®] Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	11402	\$ 212.00		\$ 106.00 ⁽⁵⁾
2	11406	\$ 335.08		\$ 167.54 ⁽⁵⁾
Base (1)	29830	\$ 654.44		
3	29835	\$ 729.80	\$ 75.36 ⁽³⁾	\$ 75.36 ⁽⁴⁾
4	29838	\$ 860.47	\$ 860.47 ⁽²⁾	\$ 860.47 ⁽⁴⁾
Total Allowed Amount in Non-Facility Setting:			\$ 1209.37 ⁽⁶⁾	

- (1) Base code listed is for reference only (not included on bill form).
- (2) Allowed amount for the highest valued arthroscopy procedure is the fee schedule maximum.
- (3) Allowed amount for the second highest valued arthroscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.
- (4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or procedure group being paid at 100%.
- (5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
- (6) Represents total allowed amount after applying all applicable global surgery policies.

MICROSURGERY

CPT® code 69990 is an "add-on" surgical code that indicates an operative microscope has been used. As an "add-on" code, it is not subject to multiple surgery rules.

CPT® code 69990 is not payable when:

- Using magnifying loupes or other corrected vision devices, or
- Use of the operative microscope is an inclusive component of the procedure, (i.e., the procedure description specifies that microsurgical techniques are used), or
- Another code describes the same procedure being done with an operative microscope.
 For example, CPT® code 69990 may not be billed with CPT® code 31535 because CPT® code 31536 describes the same procedure using an operating microscope. The table below contains a complete list of all such codes.

CPT® Codes Not Allowed with CPT® 69990

CPT [®] Code	CPT [®] Code	CPT [®] Code	CPT [®] Code
15756-15758	26551-26554	31540-31546	61548
15842	26556	31560-31561	63075-63078
19364	31520	31570-31571	64727
19368	31525-31526	43116	64820-64823
20955-20962	31530-31531	43496	65091-68850
20969-20973	31535-31536	49906	

SPINAL INJECTION POLICY

Injection procedures are divided into three categories:

- Injection procedures that require fluoroscopy.
- 2. Injection procedures that may be done without fluoroscopy when performed at a certified or accredited facility by a physician with privileges to perform the procedure at that facility. These procedures require fluoroscopy if they are not performed at a certified or accredited facility.
- 3. Injection procedures that do not require fluoroscopy.

Definition of Certified or Accredited Facility

The department defines a certified or accredited facility as a facility or office that has certification or accreditation from one of the following organizations:

- 1. Medicare (CMS Centers for Medicare and Medicaid Services)
- 2. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- 3. Accreditation Association for Ambulatory Health Care (AAAHC)
- 4. American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
- 5. American Osteopathic Association (AOA)
- 6. Commission on Accreditation of Rehabilitation Facilities (CARF)

Spinal Injection Procedures that Require Fluoroscopy

CPT®

Code	CPT [®] Fluoroscopy Codes ^{(1),(2)}
62268	76003, 76360, 76942
62269	76003, 76360, 76942
62281	76005, 72275
62282	76005, 72275
62284	76005, 76360, 76942, 72240,
	72255, 72265, 72270
62290	72295
62291	72285
62292	72295
62294	76003, 76005, 76360, 75705
62310	76005, 72275
62311	76005, 72275
62318	76005, 72275
62319	76005, 72275
64470	76005
64472	76005
64475	76005
64476	76005
64479	76005, 72275
64480	76005, 72275
64483	76005, 72275
64484	76005, 72275

- (1) One of the indicated fluoroscopy codes must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied.
- (2) Only one of the indicated fluoroscopy codes may be billed for each injection.

Spinal Injection Procedures that May Be Done Without Fluoroscopy

Interlaminar epidural steroid injections may be performed without fluoroscopy if performed at a certified or accredited facility by a physician with privileges to perform the procedure at that facility. The physician must decide whether to use fluoroscopy based on sound medical practice.

To be payable, these spinal injections must include a facility place of service code and documentation that the procedure was performed at a certified or accredited facility.

CPT® Code

62310
62311
62318
62319

Spinal Injection Procedures that Do Not Require Fluoroscopy

CPT[®] Code

62270	
62272	
62273	

Payment Methods for Spinal Injection Procedures

Provider Type	Procedure Type	Payment Method
Physician or CRNA/ARNP	Injection	–26 Component of Professional Services Fee Schedule
	Radiology	–26 Component of Professional Services Fee Schedule
Radiology Facility	Injection	No Facility Payment
	Radiology	-TC Component of Professional Services Fee Schedule
Hospital ⁽¹⁾	Injection	APC or POAC
	Radiology ⁽²⁾	APC or –TC Component of Professional Services Fee Schedule
ASC	Injection	ASC Fee Schedule
	Radiology	-TC Component of Professional Services Fee Schedule

- (1) Payment method depends on a hospital's classification.
- (2) Radiology codes may be packaged with the injection procedure.

REGISTERED NURSES AS SURGICAL ASSISTANTS

Licensed registered nurses may perform surgical assistant services if the registered nurse submits the following documents to the insurer.

- 1. A photocopy of her or his valid and current registered nurse license, and
- 2. A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Note: The department also requires a completed provider application.

Payment for these services is 90% of the allowed fee that would otherwise be paid to an assistant surgeon.

PROCEDURES PERFORMED IN A PHYSICIAN'S OFFICE

Modifier –SU denotes the use of facility and equipment while performing a procedure in a physician's office.

Modifier –SU is not covered and the department will not make a separate facility payment. Procedures performed in a physician's office are paid at non-facility rates that include office expenses.

Physicians' offices must meet ASC requirements to qualify for separate facility payments. Refer to Chapter 296-23B WAC for information about the requirements.

MISCELLANEOUS

Angioscopy

Payment for angioscopies CPT[®] code 35400 is limited to only one unit based on its complete code description encompassing multiple vessels. The work involved with varying numbers of vessels was incorporated in the RVUs.

Autologous Chondrocyte Implant

The insurer may cover autologous chondrocyte implant (ACI) when all of the guidelines outlined in Provider Bulletin 03-02, *Coverage Decisions*, are met. ACI requires prior authorization.

In addition to the clinical guidelines for the procedure, the surgeon must have received training through Genzyme Biosurgery and have performed or assisted with 5 ACI procedures or perform ACI under the direct supervision and control of a surgeon who has performed 5 or more ACI procedures.

The appropriate CPT® code for the implant is 27412. Use CPT® code 29870 for harvesting the chondrocytes.

If the procedure is authorized, the insurer will pay US Bioservices for Carticel® (autologous cultured chondrocytes). For more information, go to http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp.

Bone Morphogenic Protein

The insurer may cover the use of bone morphogenic protein as an alternative to autograft in recalcitrant long bone nonunion where use of autograft is not feasible and alternative treatments have failed. It may also cover its use for spinal fusions in patients with degenerative disc disease at one level from L4-S1.

CPT® codes used for billing depend on the specific procedure being performed.

All of the criteria and guidelines outlined in Provider Bulletin 04-01, *Coverage Decisions, July 2003 to December 2003* must be met before the department will authorize the procedures. For more information, go to

http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp.

In addition, lumbar fusion guidelines must be met. Information about the guidelines can be found at http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/TreatGuide/default.asp

Closure of Enterostomy

Closures of enterostomy are not payable with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy. CPT® code 44139 will be denied if it is billed with CPT® code 44625 or 44626.

Meniscal Allograft Transplantation

The insurer may cover meniscal allograft transplantation when all of the guidelines outlined in Provider Bulletin 03-02, Coverage Decisions, are met. Meniscal allograft transplantation requires prior authorization.

In addition to the clinical guidelines for the procedure, the surgeon must have performed or assisted with 5 meniscal allograft transplants or perform the transplant under the direct supervision and control of a surgeon who has performed 5 or more transplants. For more information, go to

http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/SpecCovDec/default.asp.

ANESTHESIA SERVICES

Anesthesia payment policies are established by the department with input from the Reimbursement Steering Committee (RSC) and the Anesthesia Technical Advisory Group (ATAG). The RSC is a standing committee with representatives from L&I, DSHS and HCA. The ATAG includes anesthesiologists, CRNAs and billing professionals.

NON-COVERED AND BUNDLED SERVICES

Anesthesia Assistant Services

The department does not cover anesthesia assistant services.

Non-Covered Procedures

Anesthesia is not payable for procedures that are not covered by the department. Refer to **Appendix D** for a list of non-covered procedures.

Patient Acuity

Patient acuity does not affect payment levels. Payment for CPT® codes 99100, 99116, 99135 and 99140 is considered bundled and is not payable separately. CPT® physical status modifiers (–P1 to –P6) and CPT® five-digit modifiers are not accepted.

Anesthesia by Surgeon

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the RBRVS payment for the procedure. Services billed with modifier –47 (anesthesia by surgeon) are considered bundled and are not payable separately.

CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)

CRNA services are paid at a maximum of 90% of the allowed fee that would otherwise be paid to a physician.

Refer to WAC 296-23-240 for licensed nursing rules and 296-23-245 for licensed nursing billing instructions. For more detailed billing instructions, including examples of how to submit bills, refer to the department's CMS-1500 billing instructions (publication F248-094-000).



CRNA services should not be reported on the same CMS-1500 form used to report anesthesiologist services; this applies to solo CRNA services as well as team care.

MEDICAL DIRECTION OF ANESTHESIA (TEAM CARE)

The department follows CMS's policy for medical direction of anesthesia (team care).

Requirements for Medical Direction of Anesthesia

Physicians directing qualified individuals performing anesthesia must:

- Perform a pre-anesthetic examination and evaluation, and
- Prescribe the anesthesia plan, and
- Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence, and
- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions, and
- Monitor the course of anesthesia administration at frequent intervals, and
- Remain physically present and available for immediate diagnosis and treatment of emergencies, and
- Provide indicated post-anesthesia care.

In addition, physicians directing anesthesia:

- May direct no more than four anesthesia services concurrently, and
- May not perform any other services while directing the single or concurrent services.

The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

Documentation Requirements for Team Care

The physician must document in the patient's medical record that the medical direction requirements were met. The physician does not need to submit this documentation with the bill. but must make the documentation available to the insurer upon request.

Billing for Team Care

When billing for team care situations:

- Anesthesiologists and CRNAs must report their services on separate CMS-1500 forms using their own provider account numbers.
- Anesthesiologists must use the appropriate modifier for medical direction or supervision (-QK or -QY).
- CRNAs should use modifier –QX.

Payment for Team Care

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services. (Refer to Anesthesia Payment Calculation in the Anesthesia Services Paid with Base and Time Units section.)
- The maximum payment to the physician is 50% of the maximum payment for solo physician services.
- The maximum payment to the CRNA is 45% of the maximum payment for solo physician services (90% of the other 50% share).

ANESTHESIA SERVICES PAID WITH BASE AND TIME UNITS

Most anesthesia services are paid with base and time units. These services should be billed with CPT[®] anesthesia codes 00100 through 01999 and the appropriate anesthesia modifier.

Anesthesia Base Units

Most of the department's anesthesia base units are the same as the 2004 anesthesia base units adopted by CMS. The department diverges from the CMS base units for some procedure codes based on input from the ATAG. The anesthesia codes, base units and base sources are listed in the Professional Services Fee Schedule.

Anesthesia Time

Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent).

Anesthesia time ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under postoperative supervision). Anesthesia must be billed in one-minute time units.



List only the time in minutes on your bill. Do not include the base units. The appropriate base units will be automatically added by the department's payment system when the bill is processed.

Anesthesia Modifiers

Anesthesiologists and CRNAs should use the modifiers in this section when billing for anesthesia services paid with base and time units. With the exception of modifier –99, these modifiers are not valid for anesthesia services paid by the RBRVS method.

Services billed with CPT® five-digit modifiers and physical status modifiers (P1 through P6) will not be paid. Refer to a current CPT® or HCPCS book for complete modifier descriptions and instructions.

CPT® Modifier

For Use By	Modifier	Brief Description	Notes
Anesthesiologists and CRNAs	- 99	Multiple modifiers	Use this modifier when five or more modifiers are required. Enter –99 in the modifier column on the bill. List individual descriptive modifiers elsewhere on the billing document.

HCPCS Modifiers

For

	Use By	Modifier	Brief Description	Notes
	jists	–AA	Anesthesia services performed personally by anesthesiologist	
Anesthesiologists		–QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individual	Payment based on policies for team services.
	Anestl	–QY	Medical direction of one CRNA for a single anesthesia procedure	Payment based on policies for team services.
CRNAs*		–QX	CRNA service: with medical direction by a physician	Payment based on policies for team services.
		–QZ	CRNA service: without medical direction by a physician ⁽¹⁾	Maximum payment is 90% of the maximum allowed for physician services.

⁽¹⁾ Bills from CRNAs that do not contain a modifier are paid based on payment policies for team services.

Anesthesia Payment Calculation

The maximum payment for anesthesia services paid with base and time units is calculated using the base value for the procedure, the time the anesthesia service is administered and the department's anesthesia conversion factor.

The anesthesia conversion factor is published in WAC 296-20-135. For services provided on or after July 1, 2006, the anesthesia conversion factor is \$ 44.55 per 15 minutes (\$ 2.97 per minute). Providers are paid the lesser of their charged amount or the department's maximum allowed amount.

To determine the maximum payment for physician services:

- 1. Multiply the base units listed in the fee schedule by fifteen.
- 2. Add the value from step 1 to the total number of whole minutes.
- 3. Multiply the result from step 2 by \$ 2.97.

The maximum payment for services provided by a CRNA is 90% of the maximum payment for a physician.

Example: CPT[®] code 01382 (anesthesia for knee arthroscopy) has 3 anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

- 1. Base units $x 15 = 3 \times 15 = 45$ base units,
- 2. 45 base units + 60 time units (minutes) = 105 base and time units,
- 3. Maximum payment for physicians = $105 \times 2.97 = 311.85$

ANESTHESIA ADD-ON CODES

Anesthesia add-on codes should be billed with a primary anesthesia code. There are three anesthesia add-on codes in the CPT® book: 01953, 01968 and 01969. CPT® add-on code 01953 should be billed with primary code 01952. CPT® add-on codes 01968 and 01969 should be billed with primary code 01967.

Anesthesia add-on codes 01968 and 01969 should be billed in the same manner as other anesthesia codes paid with base and time units. Providers should report the total time for the add-on procedure (in minutes) in the "Units" column (Field 24G) of the CMS-1500 form.

Anesthesia for Burn Excisions or Debridement

The anesthesia add-on code for burn excision or debridement, CPT[®] code 01953, must be billed according to the instructions in the following table.

Total Body Surface Area	Primary Code	Units of Add-On Code 01953
Less than 4 percent	01951	None
5 - 9 percent	01952	None
Up to 18 percent	01952	1
Up to 27 percent	01952	2
Up to 36 percent	01952	3
Up to 45 percent	01952	4
Up to 54 percent	01952	5
Up to 63 percent	01952	6
Up to 72 percent	01952	7
Up to 81 percent	01952	8
Up to 90 percent	01952	9
Up to 99 percent	01952	10

ANESTHESIA SERVICES PAID BY THE RBRVS METHOD

Some services commonly performed by anesthesiologists and CRNAs are not paid with anesthesia base and time units. These services include anesthesia evaluation and management services, most pain management services and other selected services. These services paid by the RBRVS payment method and are listed in Appendix F.

Modifiers

Anesthesia modifiers -AA, -QK, -QX, -QY and -QZ are not valid for services paid by the RBRVS method.

Refer to a current CPT® or HCPCS book for a complete list of modifiers and descriptions. Refer to **Appendix E** for a list of modifiers that affect payment.

Maximum Payment

Maximum fees for services paid by the RBRVS method are located in the Professional Services Fee Schedule.



When billing for services paid with the RBRVS method, enter the total number of times the procedure is performed, not the total minutes, in the "Units" column (Field 24G on the CMS-1500 bill form).

E/M Services Payable with Pain Management Procedures

An E/M service is payable on the same day as a pain management procedure only when:

- It is the patient's initial visit to the practitioner who is performing the procedure, or
- The E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service. (see Using the -25 modifier)

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action. The use of E/M codes on days after the procedure is performed is subject to the global surgery policy (refer to the Surgery Services section).

Injection Code Treatment Limits

Details regarding treatment guidelines and limits for the following kinds of injections can also be found in WAC 296-20-03001. Refer to Medication Administration in the Other Medicine Services section for information on billing for medications.

> Injection **Treatment Limit**

Epidural and caudal injections of substances other than anesthetic or contrast solution	Maximum of six injections per acute episode are allowed.
Facet injections	Maximum of four injection procedures per patient are allowed.
Intramuscular and trigger point injections of steroids and other non-scheduled medications and trigger point dry needling ⁽¹⁾	Maximum of six injections per patient are allowed.

⁽¹⁾ Dry needling is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. The department does not cover acupuncture services (WAC 296-20-03002). Dry needling of trigger points should be billed using trigger point injection codes. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(14).

RADIOLOGY

X-RAY SERVICES

Repeat X-Rays

No payment will be made for excessive or unnecessary x-rays. Repeat or serial x-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s) when need is supported by documented changes in objective findings or subjective complaints.

Number of Views

There is no code that is specific for additional views for radiology services. Therefore, the number of views of x-rays that may be paid is determined by the CPT® description for the

For example, the following CPT® codes for radiologic exams of the spine are payable as outlined below:

CPT [®] Code	Payable
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72020	Once for a single view
72040	Once for two to three cervical views
72050	Once for four or more cervical views
72052	Once, regardless of the number of cervical views it takes to complete the series

Incomplete Full Spine Studies

A full spine study is a radiologic examination of the entire spine; anteroposterior (AP) and lateral views. Depending on the size of the film and the size of the patient, the study may require up to six films (the AP and lateral views of the cervical, thoracic and lumbar spine). An incomplete full spine study is one in which the entire AP or lateral view is taken, but not both. For example, a study is performed in which all AP and lateral views are obtained except

Incomplete full spine studies in which five views are obtained are payable at the maximum fee schedule amount for CPT® code 72010. Incomplete full spine studies in which four views are taken are payable at one-half the maximum fee schedule amount for CPT® code 72010 and must be billed with a -52 modifier to indicate reduced services.

-RT and -LT Modifiers

for the lateral thoracic.

HCPCS modifiers –RT (right side) and –LT (left side) do not affect payment, but may be used with CPT[®] radiology codes 70010-79999 to identify duplicate procedures performed on opposite sides of the body.

Portable X-Rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving extremities, pelvis, vertebral column or skull
- Chest or abdominal films that do not involve the use of contrast media
- Diagnostic mammograms

HCPCS codes for transportation of portable x-ray equipment R0070 (one patient) or R0075 (multiple patients) may be paid in addition to the appropriate radiology code(s). R0075 will pay based on the number of patients served and the modifier billed. Payment is outlined in the table below.

	ICPCS Code	Modifier	Patients Served	Description	Fee
	R0070	Modifier	1	Transport portable x-ray	\$ 150.00
F	R0075	–UN	2	Transport portable x-ray	\$ 75.00
F	R0075	–UP	3	Transport portable x-ray	\$ 50.00
F	₹0075	–UQ	4	Transport portable x-ray	\$ 37.50
F	R0075	–UR	5	Transport portable x-ray	\$ 30.00
F	R0075	-US	6 or more	Transport portable x-ray	\$ 25.00

Custody

X-rays must be retained for ten years. See WACs 296-20-121 and 296-23-140(1).

RADIOLOGY CONSULTATION SERVICES

CPT® code 76140 is not covered. For radiology codes where a consultation service is performed, providers must bill the specific x-ray code with the modifier –26.

Separate payment will not be made for review of films taken previously or elsewhere if a face-to-face service is performed on the same date as the x-ray review. Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit or other procedure(s) performed.

Payment for a radiological consultation will be made at the established professional component (modifier –26) rate for each specific radiology service. A written report of the radiology consultation is required.

CONTRAST MATERIAL

Separate payment will not be made for contrast material unless a patient requires low osmolar contrast media (LOCM). LOCM may be used in intrathecal, intravenous and intra-arterial injections for patients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting,
- A history of asthma or allergy,
- Significant cardiac dysfunction including recent imminent cardiac decompensation, arrhythmias, unstable angina pectoris, recent myocardial infarction and pulmonary hypertension,
- Generalized severe debilitation, or
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS code in the table below. The brand name of the LOCM and the dosage must be documented in the patient's chart. HCPCS codes and payment levels are listed in the Professional Services Fee Schedule.

HCPCS Code	Abbreviated Description
00045	LOOM + 440 look to all a - 4 1

Q9945	LOCM <=149mg/ml iodine,1ml
Q9946	LOCM 150-199mg/ml iodine,1ml
Q9947	LOCM 200-249mg/ml iodine,1ml
Q9948	LOCM 250-299mg/ml iodine,1ml
Q9949	LOCM 300-349mg/ml iodine,1ml
Q9950	LOCM 350-399mg/ml iodine,1ml
Q9951	LOCM >= 400 mg/ml iodine,1ml



HCPCS codes for LOCM are paid at a flat rate based on the AWP per ml. Bill one unit per ml. A4644. A4645. A4646 and A9525 are not valid codes for LOCM.

NUCLEAR MEDICINE

The standard multiple surgery policies apply to the following radiology codes for nuclear medicine services.

CPT® Code

78306	
78320	
78802	
78803	
78806	
78807	

The multiple procedures reduction will be applied when these codes are billed:

- With other codes that are subject to the standard multiple surgery policy, and
- For the same patient, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice.

Refer to the Surgery Services section for more information about the standard multiple surgery payment policies.

PHYSICAL MEDICINE

GENERAL INFORMATION

Physical and occupational therapy services must be ordered by the worker's attending doctor or by the physician assistant for the attending doctor.

Who May Bill For Physical Medicine Services

Board Certified Physical Medicine and Rehabilitation (Physiatry) Physicians

Medical or Osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation may provide physical medicine service and use CPT® codes 97001 through 97799 to bill for their services. CPT® code 64550 may also be used but is payable only once per claim (see WAC 296-21-290).

Licensed Physical Therapists

Physical therapy services must be provided by a licensed physical therapist or a physical therapist assistant serving under the direct supervision of a licensed physical therapist (see WAC 296-23-220).

Licensed Occupational Therapists

Occupational therapy services must be provided by a licensed occupational therapist or occupational therapist assistant serving under the direction of a licensed occupational therapist (see WAC 296-23-230).

Non-Board Certified/Qualified Physical Medicine Providers

Special payment policies apply for attending doctors who are not board qualified or certified in physical medicine and rehabilitation:

- Attending doctors who are not board qualified or certified in physical medicine and rehabilitation will not be paid for CPT[®] codes 97001-97799. They may perform physical medicine modalities and procedures described in CPT[®] codes 97001-97750 if their scope of practice and training permit it, but must bill local code 1044M for these services.
- Local code 1044M is limited to six visits per claim, except when the attending doctor practices in a remote location where no licensed physical therapist is available.
- After six visits, the patient must be referred to a licensed, physical therapist or physiatrist for such treatment except when the attending doctor practices in a remote location. Refer to WAC 296-21-290 for more information.

PHYSICAL AND OCCUPATIONAL THERAPY

Billing Codes

Physical and occupational therapists must use the appropriate physical medicine CPT® codes 97001-97799, with the exceptions noted later in this section. In addition, physical and occupational therapists must bill the appropriate covered HCPCS codes for miscellaneous materials and supplies. For information on surgical dressings dispensed for home use, refer to the Supplies, Materials and Bundled Services section.

If more than one patient is treated at the same time use CPT® code 97150. Refer to the Physical Medicine CPT[®] Codes Billing Guidance section for additional information.

Non-Covered and Bundled Codes

The following physical medicine codes are not covered:

Code		
CPT® 97005		
CPT® 97006		
CPT® 97033		

The following are examples of bundled items or services:

- Application of hot or cold packs.
- Ice packs, ice caps and collars.
- Electrodes and gel.
- Activity supplies used in work hardening, such as leather and wood.
- Exercise balls.
- Thera-taping.
- Wound dressing materials used during an office visit and/or physical therapy treatment.

Refer to the appendices for complete lists of non-covered and bundled codes.

Units of Service

Supervised modalities and therapeutic procedures that do not list a specific time increment in their description are limited to one unit per day:

Code	Code
CPT® 97001	CPT® 97018
CPT® 97002	CPT® 97022
CPT® 97003	CPT® 97024
CPT® 97004	CPT® 97026
CPT® 97012	CPT® 97028
CPT® 97014	CPT® 97150
CPT® 97016	

Daily Maximum for Services

The daily maximum allowable fee for physical and occupational therapy services (see WAC 296-23-220 and WAC 296-23-230).....\$ 109.92

The daily maximum applies to CPT[®] codes 64550 and 97001-97799 when performed for the same claim for the same date of service. If both physical and occupational therapy services are provided on the same day, the daily maximum applies once for each provider type.

The daily maximum allowable fee does not apply to performance based physical capacities examinations (PCEs), work hardening services, work evaluations or job modification/pre-job accommodation consultation services.

PHYSICAL AND OCCUPATIONAL THERAPY EVALUATIONS

Physical and occupational therapy evaluations and re-evaluations must be billed with CPT[®] codes 97001 through 97004.

CPT® codes 97001 and 97003 are used to report the evaluation by the physician or therapist to establish a plan of care.

CPT® codes 97002 and 97004 are used to report the evaluation of a patient who has been under a plan of care established by the physician or therapist in order to revise the plan of care. There is no limit as to how frequently CPT® codes 97002 and 97004 can be billed.

PHYSICAL CAPACITIES EVALUATION

The following local code is payable only to physicians who are board qualified or certified in physical medicine and rehabilitation, and physical and occupational therapists.

POWERED TRACTION THERAPY

Powered traction devices are covered as a physicial medicine modality under existing physicial medicine payment policy. The department will not pay any additional cost when powered devices are used. Published literature has not substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices.

When powered traction is a proper and necessary treatment, the insurer will pay for powered traction therapy administered by a qualified provider.

Only board certified medical or osteopathic physicians may use CPT® code 97012 to bill for this therapy.

Non-board certified/qualified physical medicaine providers must use 1044M. Therapy is limited to six visits except when doctor practices in a remote area.

Only one unit of the appropriate billing code will be paid per visit, regardless of the length of time the treatment is applied.

WOUND CARE

Debridement

Therapists may not bill the surgical CPT® codes for wound debridement. Therapists must bill CPT® 97597, 97598 or 97602 when performing wound debridement that exceeds what is incidental to a therapy (e.g., whirlpool).

Wound dressings and supplies used in the office are bundled and are not separately payable.

Wound dressings and supplies sent home with the patient for self-care can be billed with HCPCS codes appended with local modifier –1S. See the Supplies, Materials and Bundled Services section for more information.

Electrical Stimulation for Chronic Wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing. Electrical stimulation is covered for the following chronic wound indications:

- Stage III and IV pressure ulcers
- Arterial ulcers
- Diabetic ulcers
- Venous stasis ulcers

Prior authorization is required if electrical stimulation for chronic wounds is requested for use on an outpatient basis using the following criteria:

- Electrical stimulation will be authorized if the wound has not improved following 30 days of standard wound therapy.
- In addition to electrical stimulation, standard wound care must continue.
- In order for payment for electrical stimulation to continue beyond 30 days, licensed medical personnel must provide documentation of wound measurements that demonstrate improvement has occurred within the past 30 days.

Use HCPCS code G0281 to bill for electrical stimulation for chronic wounds (See Provider Bulletin 05-02).

MASSAGE THERAPY

Massage therapy is a physical medicine service and must be performed by a licensed massage therapist to be a covered service (WAC 296-23-250).

Massage therapists must bill CPT[®] code 97124 for all forms of massage therapy, regardless of the technique used. The department will not pay massage therapists for additional codes.

Massage therapists must bill their usual and customary fee and designate the duration of the massage therapy treatment.

Massage therapy is a physical medicine service and is subject to the daily maximum allowable amount of\$ 109.92

The application of hot or cold packs, anti-friction devices and lubricants (e.g., oils, lotions, emollients, etc.) are bundled into the massage therapy service and are not payable separately. Refer to WAC 296-23-250 for additional information.



Massage therapy services must be billed in 15-minute time increments. Bill one unit of $\mathsf{CPT}^{\$}$ code 97124 for each 15 minutes of massage therapy.

PHYSICAL MEDICINE CPT® CODES BILLING GUIDANCE

The following provides guidance regarding the use of CPT® codes 97032-97036, 97110-97124, 97140, 97530-97542 and 97750-97762.

Timed Codes

Several CPT® codes used for therapy modalities, procedures and tests and measurements specify that the direct (one-on-one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on any calendar day using CPT® codes and the appropriate number of units of service. For any single CPT[®] code, providers bill a single 15minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes and less than 38 minutes, then 2 units must be billed. Time intervals for the number of units are as follows:

Units Reported on the Claim	Number Minutes
1 unit	≥ 8 minutes to < 23 minutes
2 units	≥ 23 minutes to < 38 minutes
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥113 minutes to < 128 minutes

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

If more than one CPT® code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time.

Example 1

If 24 minutes of CPT® code 97112 and 23 minutes of CPT® code 97110 were furnished, then the total treatment time was 47 minutes; so only 3 units can be billed for the treatment. The correct coding is 2 units of CPT® code 97112 and one unit of CPT® code 97110, assigning more units to the service that took the most time.

Example 2

If a therapist delivers 5 minutes of CPT® code 97035, 6 minutes of CPT® code 97140 and 10 minutes of CPT® code 97110, then the total minutes are 21 and only one unit can be billed for the treatment. Bill one unit of CPT® code 97110 (the service provided for the longest time) and the clinical record will serve as documentation that the other two services were also performed.

Prohibited Pairs

In the same 15-minute (or other) time period, a therapist cannot bill any of the following pairs of CPT® codes for outpatient therapy services provided to the same, or to different patients.

- Any two CPT® codes for "therapeutic procedures" requiring direct, one-on-one patient contact.
- Any two CPT[®] codes for modalities requiring "constant attendance" and direct, one-on-one patient contact.
- Any two CPT[®] codes requiring either constant attendance or direct, one-on-one patient contact—as described above—. For example: any CPT[®] codes for a therapeutic procedure with any attended modality CPT[®] code.
- Any CPT[®] code for therapeutic procedures requiring direct, one-on-one patient contact with the group therapy CPT[®] code. For example: CPT[®] code 97150 with CPT[®] code 97112.
- Any CPT[®] code for modalities requiring constant attendance with the group therapy code.
 For example: (CPT[®] code 97150 with CPT[®] code 97035)
- Any un-timed evaluation or reevaluation code with any other timed or un-timed CPT[®] codes, including constant attendance modalities, therapeutic procedures and group therapy.

DETERMINING WHAT TIME COUNTS TOWARDS 15-MINUTE TIMED CODES

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intraservice care" begins when the therapist or physician (or a physical therapy or occupational therapy assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment. The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only one unit of the appropriate CPT® code. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services will not be exceeded.

WORK HARDENING AND WORK CONDITIONING

Work Hardening

Work hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular and psychosocial functioning of the worker.

Work hardening programs require prior approval by the worker's attending physician and prior authorization by the claim manager.

Only department approved work hardening providers will be paid for work hardening services. More information about the department's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program and other work hardening program standards is available on the department's web site at

http://www.LNI.wa.gov/ClaimsIns/Providers/Manage/RTW/WorkHard/default.asp. This information is also available by calling the Provider Hotline at 1-800-848-0811 or the work hardening program reviewer at (360) 902-5622.

Effective July 1, 2005, work hardening evaluation is billed using local code 1001M. Treatment is billed using CPT[®] codes 97545 and 97546. These codes are subject to the following limits:

Code	Description	Unit limit	Unit price
1001M	Work hardening evaluation	6 units (1 unit = 1 hour)	\$108.93
97545	Initial 2 hours per day	20 units per program; max. one unit per day per claimant	\$107.90
97546	Each additional hour	70 units per program; add-on, will not be paid as a stand-alone procedure per claimant per day.	\$49.88

Work hardening programs are authorized for up to four weeks. Program extensions must be authorized in advance by the claim manager and are based on documentation of progress and the worker's ability to benefit from the program extension.

Providers may only bill for the time that services are provided in the presence of the client. The payment value of procedure codes 97545 and 97546 takes into consideration that some work occurs outside of the time the client is present (team conference, plan development, etc.).

Time spent in treatment conferences is not covered as a separate procedure regardless of the presence of the patient at the conference.

Billing for additional services

The provision of additional services during a work hardening program is atypical and must be authorized in advance by the claim manager. Documentation must support the billing of additional services.

Billing for less than 2 hours of service in one day

Services provided for less than two hours on any day do not meet the work hardening program standards. Therefore, the services must be billed outside of the work hardening program codes.

For example, the worker arrives for work hardening but is unable to fully participate that day. Services should be billed using CPT® codes that appropriately reflect the services provided. This should be considered as an absence in determining worker compliance with the program. The standard for participation continues to be a minimum of four hours per day, increasing each week to 7-8 hours per day by week four.

Billing less than one hour of 97546

After the first two hours of service on any day, if less than 38 minutes of service are provided the -52 modifier must be billed. For that increment of time, procedure code 97546 must be billed as a separate line item with a -52 modifier and the charged amount pro-rated to reflect the reduced level of service.

For example: Worker completes 4 hours and 20 minutes of treatment. Billing for that date of service would include three lines:

Code	Modifier	Charged Amt	Units
97545		Usual and customary	1
97546		Usual and customary	2
97546	-52	33% of usual and customary (completed 20 of 60 minutes)	1

Billing for services in multi-disciplinary programs

Each provider must bill for the services that they are responsible for each day. Both occupational and physical therapists may bill for the same date of service.

Only one unit of 97545 (first two hours) will be paid per day per claimant and the total number of hours billed should not exceed the number of hours of direct services provided.

Example: The occupational therapist is responsible for the work simulation portion of the worker's program, which lasted 4 hours. On the same day, the worker performed 2 hours of conditioning/aerobic activity that the physical therapist is responsible for. The six hours of services could be billed in one of two ways.

Option 1		
PT	1 unit 97545	2 hours
ОТ	4 units 97546	4 hours
	Total hours billed	6 hours

Option 2		
ОТ	OT 1 unit 97545 2 hours	
	+	
	2 units 97546	2 additional hours
PT	2 units 97546	2 hours
	Total hours billed	6 hours

Work Conditioning

The department does not recognize work conditioning as a special program. Work conditioning is paid according to the rules for outpatient physical and occupational therapy (see WAC 296-23-220 and WAC 296-23-230).

OSTEOPATHIC MANIPULATIVE TREATMENT

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT). CPT® code 97140 is not covered for osteopathic physicians.

For OMT services body regions are defined as: head, cervical, thoracic, lumbar, sacral, pelvic, rib cage, abdomen and viscera regions; lower and upper extremities.

These codes ascend in value to accommodate the additional body regions involved. Therefore, only one code is payable per treatment. For example, if three body regions were manipulated, one unit of the appropriate level CPT® code would be payable.

OMT includes pre- and post-service work (e.g., cursory history and palpatory examination). E/M office visit service may be billed in conjunction with OMT **only when all of the following conditions are met:**

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included with OMT, and
- There is documentation in the patient's record supporting the level of E/M billed, and
- The E/M service is billed using the –25 modifier.

E/M codes billed on the same day as OMT without the -25 modifier will not be paid.

The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

The insurer may reduce payments or process recoupments when E/M services are not documented sufficiently to support the level of service billed. The CPT® book describes the key components that must be present for each level of service.

ELECTRICAL STIMULATORS

Electrical Stimulators Used in the Office Setting

Providers using stimulators in the office setting may bill professional services for application of stimulators with the CPT® physical medicine codes when such application is within the provider's scope of practice. Attending doctors who are not board qualified or certified in physical medicine and rehabilitation must bill local code 1044M as stated in a previous section.

Devices and Supplies for Home Use or Surgical Implantation

See the Transcutaneous Electrical Nerve Stimulators (TENS) section for policies pertaining to TENS units and supplies. Coverage policies for other electrical stimulators and supplies are described below.

Electrical Stimulator Devices for Home Use or Surgical Implantation

Code	Brief Description	Coverage Status	
E0744	Neuromuscular stim for scoli	Not covered	
E0745	Neuromuscular stim for shock	Covered for muscle denervation only. Prior authorization is required.	
E0747	Elec Osteo stim not spine	Prior authorization is required.	
E0748	Elec Osteogen stim spinal	Prior authorization is required	
E0749	Elec Osteogen stim, implanted	Authorization subject to utilization review.	
L8680	Implantable neurostimulator electrode	UW study only	
E0755	Electronic salivary reflex s	Not covered	
E0760	Osteogen ultrasound, stimltor	Covered for appendicular skeleton only (not the spine). Prior authorization is required.	
E0761	Nontherm electromgntc device	Covered	
E0762	Trans elec jt stim dev sys	Not covered	
E0764	Functional neuromuscular stimulator	Prior authorization is required	
E0765	Nerve stimulator for tx n&v	Not covered	
E0769	Electric wound treatment dev	Not covered	

Electrical Stimulator Supplies for Home Use HCPCS

Code	Brief Description	Coverage Status	
A4365	Adhesive remover wipes	Payable for home use	
A4455	Adhesive remover per	only	
	ounce	Bundled for office use	
A4556	Electrodes, pair		
A4557	Lead wires, pair		
A4558	Conductive paste or gel		
A5120	Skin barrier wipes box pr		
	50		
A6250	Skin seal protect		
	moisturizr		
E0731	Conductive garment for	Not covered	
	TENS		
E0740	Incontinence treatment	Not covered	
	system		

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

Prescribing TENS

Providers, both in and out-of-state, who prescribe or dispense TENS units for State Fund injured workers must use the department's contracted vendor, Performance Modalities, Inc. (PMI) per WAC 296-23-165(1)(b). TENS units may be prescribed by licensed medical, osteopathic, naturopathic and podiatric physicians, ARNPs and dental surgeons. Licensed chiropractors (DCs) are excluded from prescribing TENS units per WAC 246-808-640.

Note: Physical and occupational therapists may only fit workers with TENS units upon referral by the provider types listed above.

PMI can be contacted at:

Performance Modalities, Inc.

19625 62nd Avenue South Suite A-101

Kent. WA 98032-1106

Phone: (253) 852-0078

(800) 999-TENS

Fax: (253) 852-0427

Services Provided by PMI

PMI has technical specialists who provide assistance and answer questions regarding the TENS models available through the contract. In addition, PMI has a customer service department that provides support to both workers and providers.

Some services provided by PMI's technical, customer service, and quality programs include:

- Technical instructions to individual clinics and providers on an as-needed basis;
- Training to individual or groups of Washington TENS providers. During the training sessions, PMI will, at a minimum, present information about the contracted TENS units, supplies, and services provided under the department's TENS contract. Hands-on training for all the TENS units in the contract will also be provided;
- Visits to clinics with inventories of TENS units and supplies at least every six weeks;
- Provides a toll-free number for providers and workers with questions and requests for more information;
- Provides follow-up calls to new TENS patients to ensure they understand how to properly
 use the unit and accessories;
- Meets the needs of injured workers whose primary language is not English; and
- In exceptional circumstances, will be available to provide at-home instruction and assistance to TENS patients.

Dispensing TENS

Providers may have on-site inventories of some or all of the TENS units included in the department's TENS contract with PMI, or may order a TENS unit from PMI by calling 1-800-999-TENS (1-800-999-8367).

- In special cases the department's medical director or designee may approve requests for TENS units that are not listed in the contract. The units must be obtained through PMI.
- Additional TENS units and updated TENS unit models may be added to the contract with the department's approval.

Providers who maintain an inventory of TENS units must notify PMI when they have dispensed a unit and PMI will replenish the inventory. For those providers who do not have inventories of TENS units, contact PMI and a unit will be express mailed, most often within one day of the request.

Electrotherapy standards are set by the US Food and Drug Administration (FDA 510(k) and classified into three categories:

- TENS units
- Interferential current stimulators
- Neuromuscular stimulators

The department's definition of TENS therapy includes TENS units and interferential current stimulators. Neuromuscular stimulators do not fall under the TENS definition.

Providers may prescribe and dispense the following TENS units:

MANUFACTURER TENS UNIT Interspec-IF⁽¹⁾ American Imex MicroCare II American Imex Premier AP American Imex **Electromedical Products** Alpha-Stim 100 Dynex V Empi Eclipse + **Empi** Epix VT **Empi** Epix XL **Empi** Sparta Spectrum Max-SD

TENS Instruction

The department allows the initial TENS application and training by a physical therapist or other qualified provider only once per claim. This service must be billed with CPT[®] code 64550.

Trial Evaluation Period

A provider may dispense a TENS unit to an injured worker for a free trial evaluation period. Prior authorization is not required for the trial evaluation.

The trial evaluation period begins when the TENS unit is dispensed and may last up to 30 days. During the trial evaluation period, the provider and the injured worker assess whether the TENS treatment is working and if rental of the unit is medically necessary.

RENTAL AND PURCHASE OF TENS

TENS rental or purchase requires authorization by the department, per WAC 296-20-03001(9), WAC 296-20-1102 and WAC 296-23-165(3). Vendors who attempt to bill the department for TENS units without authorization will not be paid.

Rental Period

The department requires a 30-day trial evaluation period before TENS rental will be considered.

If the TENS unit is beneficial during the trial evaluation period, PMI will request authorization for a four-month rental period. If authorized, the four-month authorization is dated from the day the TENS unit was initially dispensed for the trial evaluation.

Providers may request authorization for rental of a TENS unit by contacting PMI at 1-800-999-TENS (1-800-999-8367).

⁽¹⁾ This unit is classified by the FDA as a true interferential current stimulator. Only the interferential units listed in the PMI contract with the department are eligible for rental and purchase on an at-home basis. Interferential units must be obtained from PMI.

Purchase

The department requires a four-month rental period before TENS purchase will be considered.

After a TENS unit has been rented for three months, PMI will send a *TENS Purchase Recommendation* form to the prescribing provider.

At the end of the four-month rental period, the prescribing provider must decide whether or not to pursue purchasing a TENS unit for the injured worker. If an injured worker continues to exhibit substantial, measurable improvement as a direct result of TENS therapy, the prescribing provider may request purchase of the unit by completing the *TENS Purchase Recommendation* form (see Requesting Purchase of a TENS unit below for details).

If the prescribing provider does not believe purchase of the TENS unit will be of benefit to the worker, the prescribing provider must check box 12 on the *TENS Purchase Recommendation* form, sign and return it to PMI.

The department will purchase only one TENS unit per claim unless:

- The worker's TENS unit is worn-out, obsolete, or not repairable;
- A replacement TENS unit with improved and/or more advanced technology will substantially benefit the worker;
- The worker's medical condition has changed sufficiently to warrant another attempt at TENS therapy after an initial failed attempt.

If a worker's claim is ready for closure prior to the completion of four months of TENS rental, the claim manager may authorize early purchase of the TENS unit if TENS therapy is determined to be beneficial.

Requesting Purchase of a TENS Unit:

If the prescribing provider decides that purchase of the TENS unit will benefit the worker, the prescribing provider should request purchase by:

- 1. Completing the TENS Purchase Recommendation form.
- 2. After completing the form, send it back to PMI.
- 3. PMI will forward your request to the Department of Labor and Industries.
- 4. A L&I medical consultant familiar with electrotherapy will review your request and provide a medical perspective as to whether the request is substantiated by the objective medical evidence included on the form.
- 5. After the medical consultant has completed the TENS purchase review, PMI will contact the L&I Provider Hotline to request authorization for TENS unit purchase.
- 6. The purchase decision will be communicated to PMI. If L&I denies TENS purchase, PMI will contact the requesting provider and injured worker.

NOTE: Prescribing providers are not permitted to bill L&I for completion of the *TENS Purchase Recommendation* form.

Denial and Second Purchase Review

If the TENS unit purchase request is denied and the prescribing provider and injured worker disagree with the department's decision, the provider may submit a written request for a second purchase review.

The second purchase review must be submitted to PMI and must include additional objective information supporting both the injured worker's functional improvement and the effectiveness of TENS therapy.

PMI will submit the second purchase request to the department for consideration and will notify the provider and the injured worker of the department's authorization decision.

When a TENS Unit is No Longer Authorized

Per RCW 51.28.020 and WAC 296.20-020, an injured worker with an accepted claim with the department is entitled to benefits and may not be charged for any costs of treatment deemed appropriate for that claim. This includes postage for any items returned by mail.

When a TENS unit is no longer authorized by L&I, PMI will contact the prescribing provider and injured worker by letter, notifying them the TENS unit must be returned. All TENS units come with a postage paid, self-addressed package for easy return. If the injured worker should lose the return packaging, PMI will send replacement packaging at no charge.

The injured worker's TENS unit is owned by PMI. If the unauthorized TENS unit is not returned to PMI, PMI can bill the injured worker for all charges related to TENS rental, purchase, supplies and repair that accrue after TENS authorization is denied by the department.

TENS Supplies and Batteries

The department will pay for medically necessary supplies and batteries for the life of the TENS unit if the department has authorized the injured worker's use of the TENS unit for an accepted condition. All supplies and batteries must be obtained from PMI.

TENS Unit Repair and Replacement

TENS units dispensed on or after January 1, 2003, have a five-year warranty as long as the unit is being used by the original purchaser. TENS units dispensed prior to that date may or may not still be under warranty. Regardless of warranty status, TENS unit repair is a covered service as long as the damage to the TENS unit has not been caused by injured worker abuse, neglect or misuse. The department and PMI, at their discretion, will decide when or if to repair a TENS unit or replace it with a TENS unit comparable to the original unit. In cases where damage to the TENS unit is due to injured worker abuse, neglect or misuse, TENS unit repair or replacement is the responsibility of the injured worker. Replacement of a lost or stolen TENS unit is also the responsibility of the injured worker.

The TENS vendor is responsible for warranty-covered TENS repair or replacement. TENS warranty covers defects in workmanship and materials, including parts and labor. The vendor can decide when or if to repair a TENS unit or replace it with the same TENS unit or a TENS unit comparable to the damaged unit.

The department is responsible for non-warranted covered TENS unit repair or replacement. Non-warranty covered repair includes repair needed because of normal wear or a work related incident that damaged the unit. Non-warranty repair or replacement must be arranged through the TENS vendor. The department can decide when or if to repair a TENS unit or replace it with the same TENS unit or a TENS unit comparable to the damaged unit.

TENS Billing Codes

The department's contracted vendor and providers treating self-insured workers must use the appropriate HCPCS codes to bill for TENS units and supplies.

Sales tax and delivery charges are not separately payable and must be included in the total charge for the TENS unit and supplies.

HCPCS Code	Brief Description	Coverage Status
A4595	TENS Supp 2 lead per	For State Fund claims:
	month	Payable to the department's
A4630	Repl batt TENS own by pt	contracted TENS vendor.
E0730	TENS, four lead	For self-insured claims:
	·	Payable to DME suppliers.

CHIROPRACTIC SERVICES

Chiropractic physicians must use the codes listed in this section to bill for services. In addition, chiropractic physicians must use the appropriate CPT® codes for radiology, office visits and case management services and HCPCS codes for miscellaneous materials and supplies.

EVALUATION AND MANAGEMENT

Chiropractic physicians may bill the first four levels of new and established patient office visit codes. The department uses the CPT® definitions for new and established patients. If a provider has treated a patient for any reason within the last three years, the person is considered an established patient. Refer to a CPT® book for complete code descriptions, definitions and guidelines.

The following payment policies apply when chiropractic physicians use E/M office visit codes:

- A new patient E/M office visit code is payable only once for the initial visit.
- An established patient E/M office visit code is not payable on the same day as a new patient E/M office visit code.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier –22 is not payable with E/M codes for chiropractic services.
- Established patient E/M codes are not payable in addition to L&I chiropractic care visit codes for follow-up visits.
- Refer to the Chiropractic Care Visits section for policies about the use of E/M office visit codes with chiropractic care visit codes.

Case Management

Refer to Case Management Services, page 35, in the Evaluation and Management section for information on billing for case management services. These codes may be paid in addition to other services performed on the same day.

Consultations

Approved chiropractic consultants may bill the first four levels of CPT® office consultation codes. The department periodically publishes a policy on consultation referrals. This also includes a list of approved chiropractic consultants. The most recent Provider Bulletin can be obtained by contacting the department's Provider Hotline at 1-800-848-0811 or on the department's Provider Bulletin website at

http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp.

Physical Medicine Treatment

Local code 1044M (Physical medicine modality(ies) and/or procedure(s) by attending doctor not board qualified/certified in PM&R) may be billed up to six times per claim (not per attending doctor). Refer to the previous section Non-Board Certified/Qualified Physical Medicine providers for more information. Documentation of the visit must support billing for this procedure code.

CPT® physical medicine codes 97001-97799 are payable only to medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation per WAC 296-21-290. These codes are not payable to chiropractic physicians.

Powered Traction Devices

Powered traction devices are covered as a physical medicine modality under existing physical medicine payment policy. The department will not pay any additional cost when powered devices are used. Published literature has not substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices.

When powered traction is a proper and necessary treatment, the insurer may pay for powered traction therapy administered by a qualified provider.

Non-board certified/qualified physical medicine providers must use 1044M. Therapy is limited to six visits except when doctor practices in a remote area.

Only one unit of the appropriate billing code will be paid per visit, regardless of the length of time the treatment is applied.

For additional information see "Powered Traction Therapy", page 60, in the Physical Medicine section of this document.

Complementary and Preparatory Services

Chiropractic physicians are not separately paid for patient education or complementary and preparatory services. The department defines complementary and preparatory services as interventions that are used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment. The application of heat or cold is considered a complementary and preparatory service.

For example: routine patient counseling regarding lifestyle, diet, self-care and activities of daily living, thermal modalities or some soft tissue work, exercise instruction involving a provision of a sheet of home exercises and a description in the course of a routine office visit.

CHIROPRACTIC CARE VISITS

Chiropractic care visits are defined as office or other outpatient visits involving subjective and objective assessment of patient status, management and treatment. The levels of treatment are based on clinical complexity (similar to established patient evaluation and management services). Extremities are considered as one of the body regions and are not billed separately. CPT® codes for chiropractic manipulative treatment (CPT® 98940-98943) are not covered. The department has developed the following clinical complexity based local codes for chiropractic care visits.

2050A	Level 1: Chiropractic Care Visit (straightforward complexity)	\$ 38.35
2051A	Level 2: Chiropractic Care Visit (low complexity)	\$ 49.12
2052A	Level 3: Chiropractic Care Visit (moderate complexity)	\$ 59.84

The following payment policies apply to the use of chiropractic care visit codes:

- Only **one** chiropractic care visit code is payable per day.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier –22 will be individually reviewed when billed with chiropractic care visit local codes (2050A-2052A). A report is required detailing the nature of the unusual service and the reason it was required. Payment will vary based on findings of the review. No payment will be made when this modifier is used for non-covered or bundled services (for example: application of hot or cold packs).
- See information below for the use of chiropractic codes with E/M office visit codes.

Use of Chiropractic Care Visit Codes with E/M Office Visit Codes

Chiropractic care visit codes (local codes 2050A-2052A) are payable in addition to E/M office visit CPT® codes (99201-99204, 99211-99214) only when all of the following conditions are met:

- The E/M service is for the initial visit for a new claim; and
- The E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the chiropractic care visit; and
- Modifier -- 25 is added to the new patient E/M code; and
- Supporting documentation describing the service(s) provided is in the patient's record.



When a patient requires reevaluation for an existing claim, either an established patient E/M code or a chiropractic care local code (2050A-2052A) is payable. Payment will not be made for both. Modifier -25 is not applicable in this situation.

Selecting the Level of Chiropractic Care Visit Code

The following table outlines the treatment requirements, presenting problems and face-to-face patient time involved in the three levels of chiropractic care visits.

Clinical decision making complexity is the primary component in selecting the level of chiropractic care visit. The department defines clinical decision making complexity according to the definitions for medical decision making complexity in the Evaluation and Management Services Guidelines section of the CPT® book.

	Selecting the Level of Chiropractic Care Visit		
	Primary Component	Other Components	
	Clinical decision making is typically	Typical number of body regions ⁽¹⁾ manipulated	Typical face-to-face time with patient and/or family
Level 1 (2050A)	Straightforward	Up to 2	Up to 10-15 minutes
Level 2 (2051A)	Low complexity	Up to 3 or 4	Up to 15-20 minutes
Level 3 (2052A)	Moderate complexity	Up to 5 or more	Up to 25-30 minutes

- Body regions for chiropractic services are defined as: (1)
 - Cervical (includes atlanto-occipital joint)
 - Thoracic (includes costovertebral and costotransverse joints)
 - Lumbar
 - Sacral
 - Pelvic (includes sacro-iliac joint)
 - Extraspinal: Any and all extraspinal manipulations are considered to be one region. Extraspinal manipulations include head (including temporomandibular joint, excluding atlanto-occipital), lower extremities, upper extremities and rib cage (excluding costotransverse and costovertebral joints).

Chiropractic Care Visit Examples

The following examples of chiropractic care visits are for illustrative purposes only. They are not intended to be clinically prescriptive.

EXAMPLES

Level 1 Chiropractic Care Visit (straightforward complexity)	26-year-old male presents with mild low back pain of several days duration. Patient receives manipulation/adjustment of the lumbar region.
Level 2 Chiropractic Care Visit (low complexity)	55-year-old male presents with complaints of neck pain, midback and lower back pain. Patient receives 5 minutes of myofascial release prior to being adjusted. The cervical, thoracic and lumbar regions are adjusted.
Level 3 Chiropractic Care Visit (moderate complexity)	38-year-old female presents with headache, right anterior rib pain, low back pain with pain at the sacrococcygeal junction, as well as pain in the sacroiliac regions and right sided foot drop. Patient receives 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/adjustment to the cervical and atlanto-occipital, thoracic, anterior rib area, lumbar, sacroiliac and sacrococcygeal regions.

CHIROPRACTIC INDEPENDENT MEDICAL EXAMS

Chiropractic physicians must be on the Approved Examiners List to perform independent medical exams (IMEs). To be considered for placement on the Approved Examiners List, a chiropractic physician must have all of the following:

- Two years experience as a chiropractic consultant on the department's approved consultant list; and
- Successfully completed the department's disability rating course for Washington State;
- Attended the department's Chiropractic Consultant Seminar during the previous 24 months; and
- Submitted the written examination required for certification.

For more information, refer to the *Medical Examiners' Handbook* (publication F252-001-000). See http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/IME/MedHandbook/default.asp. Chiropractic physicians performing impairment ratings on their own patients or upon referral should refer to the *Medical Examiners' Handbook* and Impairment Rating, page 90, by Attending Doctors/Consultants later in this section.

RADIOLOGY SERVICES

Chiropractic physicians must bill diagnostic x-ray services using CPT[®] radiology codes and the policies described in the Radiology Services section. If needed, x-rays immediately prior to and immediately following the initial chiropractic adjustment may be allowed without prior authorization. X-rays subsequent to the initial study require prior authorization.

Only chiropractic physicians who are on the department's list of approved radiological consultants may bill for x-ray consultation services. To qualify, a chiropractic physician must be a Diplomate of the American Chiropractic Board of Radiology and must be approved by the department.

SUPPLIES

See the Supplies, Materials and Bundled Services section to find information about billing for supplies.

PSYCHIATRIC SERVICES

The psychiatric services policies in this section apply only to injured workers covered by the State Fund and self-insured employers (see WAC 296-21-270). For treatment guidelines refer to the Medical Treatment Guideline for Psychiatric and Psychological Evaluation at http://www.LNI.wa.gov/ClaimsIns/Files/OMD/MedTreat/MedTreatGuidelines.pdf. For information on psychiatric policies applicable to the Crime Victims' Compensation Program, refer to the department's booklet *Mental Health Treatment Rules and Fees* (F800-090-000) and Chapter 296-31 WAC.

PSYCHIATRIC CONDITIONS

Treatment may be authorized for psychiatric conditions caused or aggravated by a work-related condition. Treatment may also be temporarily authorized for unrelated psychiatric conditions that are retarding recovery of an allowed work-related condition. **However, unrelated conditions are <u>NOT</u> the responsibility of the insurer.** To assist an injured worker in recovering from an industrial injury or disease, the insurer may elect to pay for some level of treatment of such a condition. Payment for temporary treatment of unrelated conditions will stop when:

- The allowed work-related condition is resolved or
- The allowed work-related condition is no longer delayed from recovery by the unrelated psychiatric condition(s).

Psychiatric treatment must be provided in an "intensive" manner, which the department defines as at least 10-12 treatments in a 90-day authorization period. Prior authorization is required for **both** an initial psychiatric evaluation and for continued treatment. Subsequent authorization periods of 90 days or less are contingent on documented progress in psychiatric treatment.

PROVIDERS OF PSYCHIATRIC SERVICES

Authorized psychiatric services **must** be performed by either a psychiatrist (MD or DO) or a licensed psychologist (PhD), (see WAC 296-21-270). Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service. Each provider must obtain his or her own L&I provider account number for billing and payment purposes.

The insurer does not cover psychiatric evaluation and treatment services provided by social workers, psychiatric nurse practitioners, and other master's level counselors, even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. Staff supervised by a psychiatrist or licensed clinical psychologist may administer psychological testing; however, the psychiatrist or licensed clinical psychologist must interpret the testing and prepare the reports.

PSYCHIATRISTS AS ATTENDING PHYSICIANS

A psychiatrist can only be an injured worker's attending physician when the insurer has accepted a psychiatric condition and it is the **only** condition being treated. A psychiatrist may certify an injured worker's time loss from work if a psychiatric condition has been allowed and the psychiatric condition is the only condition still being treated. A psychiatrist may also rate psychiatric permanent partial disability.

Psychologists cannot be the attending provider and may not certify time loss from work or rate permanent partial disability under department rules (see WAC 296-20-210).

REPORTING REQUIREMENTS

All reports should be written in a legible style that can be understood by non-medical personnel. The psychiatrist or psychologist must submit a goal-directed treatment plan and reports that contain a summary of subjective complaints, objective observations, assessment toward meeting measurable goals, an updated intensive goal-directed treatment plan and include the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV or current edition) axis format assessment (WAC 296-21-270). The use of specific examples of a patient's behavior may be a helpful way to communicate the effects of a psychological condition, or the effects of treatment for such a condition.

Doctors treating psychiatric conditions allowed on a claim need to submit progress reports to the insurer every sixty days (see WAC 296-21-270). If temporary treatment has been authorized for an unrelated psychiatric condition, progress reports need to be submitted to the insurer every thirty days (see WAC 296-20-055).

DIAGNOSIS OF A PSYCHIATRIC CONDITION

Diagnosis is an essential first step to the development of a plan for treatment of psychiatric conditions. Diagnoses should be specific, and should use the nomenclature and numerical identification of the DSM-IV (or current edition). The diagnostic section of the initial report, and all subsequent reports, should address all five axes described in the DSM-IV (or current edition). Diagnoses should be based on all relevant historical information. Specific inquiry should be made into the patients' pre-injury and current medical, psychosocial, and psychological status. Whenever possible, prior medical records should be reviewed to screen for the presence of diagnostically important information, and for information that may be useful in the creation of a treatment plan. Carefully document any pertinent positive or negative historical information.

Consideration should be given to the use of standardized measuring tools, such as the Rollins® or Beck® scales, and the use of individualized visual analog scales. Such measurements provide both support for diagnoses and benchmarks against which progress in treatment can be measured.

IDENTIFICATION OF BARRIERS TO RECOVERY FROM AN INDUSTRIAL INJURY

Each diagnosed psychiatric condition should be assessed to determine whether it is retarding a patient's recovery from an industrial injury. Any such barriers should be clearly identified and the report should provide an explanation that links the psychiatric condition to an observable, measurable behavior that interferes with recovery from an industrial injury.

Example

Diagnosis: Depression, Major, Single episode (296.2)

Barriers created by condition:

- Insomnia: Patient is only able to sleep 2-3 hours at a time and his sleep is fitful;
- Fatigue: Patient has no energy, and feels too tired to participate in reconditioning
- Despondency: Patient does not believe he will ever again be able to return to productive employment;
- Maladaptive personality trait expression: Patient expresses anger towards employer. which is exacerbated by chronic lack of sleep, fatigue and despondency.

Specific inquiry should be made to determine whether there are employment-related risk factors that should be addressed in a health care setting. For example, anger towards the employer, supervisor or coworkers may need to be addressed. Economic disincentives, and employment-related loss of self-esteem can each contribute to the failure of a worker to make expected progress in recovery. Feelings of victimization may delay a return to a normal lifestyle. Such risk factors should be carefully identified and documented. Additional risk factors are discussed in the Attending Doctor's Handbook; Section 2 "Helping Patients Return to Work", in the "Screening Checklist for Possible Risk Factors". Additional copies of the Attending Doctor's Handbook are available without charge from the Department of Labor and Industries.

FORMULATION OF A PSYCHIATRIC TREATMENT PLAN

The psychiatrist or psychologist evaluating a worker with a psychiatric condition should create a treatment plan that addresses each diagnosed psychiatric condition and any identified barriers to recovery. The treatment plan must include intensive, goal-directed treatment and include a recommended duration of treatment. The treatment plan should be included in the evaluation report and updated throughout treatment.

Objectively determinable measurements of recovery should be identified for each condition for which treatment is proposed. Objective measurements should be individualized so that each patient's progress or lack of progress will be accurately assessed. Examples of such measurements include documentation of the level of physical activity; improved participation in physical therapy, occupational therapy, work hardening, or vocational counseling programs; normalization of common behavior patterns such as sleep cycles and eating disorders; and changes in medication usage. To the extent that a treatment plan may recommend medications, the plan should include a discussion of any predictable drug interactions the recommended medications might have with medications the worker is currently taking.

Example 1

Diagnosis: Depression, Major, Single episode (296.2)

Plan:

- Intensive Psychotherapy: Weekly for 12 weeks;
- Antidepressants: Sinequan® 50mg qhs, then increase as needed. No anticipated interaction with patient's current regimen of Motrin® and acetaminophen.

Identification of the measured variable should include a description of what will be measured, the intervals and duration during which the variable will be measured, the anticipated endpoint, and the anticipated progress to that endpoint at each interval measurement. When appropriate, use standardized measurements such as the Rollins® or Beck® scales to document the extent of recovery. Each variable to be measured should be explained to the injured worker before treatment is actually commenced. If necessary, the patient should be instructed in how to complete diaries that document such variables as pain, activity, medication use, etc.

In the event that the psychiatric treatment plan includes measurements of indicators that are outside the practice of the psychiatrist or psychologist, prior arrangements to obtain such measurements should be made by the psychiatrist or psychologist with the attending doctor. Such measurements should be available to the psychiatrist or psychologist at the time each respective progress note is created.

Example 2

Measurements arranged by the psychiatrist or psychologist and the attending doctor.

The psychiatrist evaluating a knee injury patient includes monthly measurements of flexion and extension of the knee as two of the objective determinants of whether treatment is lowering barriers to the patient's recovery from a knee injury. The psychiatrist does not measure such parameters as part of his/her practice. At the time the psychiatrist creates the treatment plan, a check should be made with the attending physician to determine whether that doctor can make monthly assessments of flexion and extension of the knee. Copies of the measurement results should be available to the psychiatrist or psychologist by the 15th of each of the next three months, for review when the injured worker is seen next. Arrangements may be made with a physical therapist to provide such measurements. The psychiatrist summarizes the arrangement in the treatment plan.

ASSESSMENT OF PSYCHIATRIC TREATMENT AND RECOMMENDATIONS

A progress note should be prepared following each clinic visit. Per WAC 296-20-06101, legible copies of progress notes must be submitted to the department for all treatment. The progress note should document the patient's interval history, and should summarize any pertinent positive or negative findings. Indicators that are measured to assess progress should be documented along with measurements obtained during the interval period. An assessment should be made as to whether the measurements reflect the expected progress.

A visual analog scale can be a useful tool in assessing a patient's perception. Generally, such scales consist of a 10 cm horizontal line with words at opposite ends of the spectrum. Studies have shown that visual analog scales are most accurately representative of that which they seek to measure when the horizontal line contains no arbitrary divisions such as numbers, interval marks, etc. The patient is instructed to place a vertical mark at the point on the line that seems most appropriate to the patient.

Should expected progress not be made, the report of the psychiatrist or psychologist should contain a discussion concerning the postulated reasons for lack of progress. If necessary, the treatment plan should be reassessed, and any necessary modifications made.

The following is an example of a progress note that includes the goal-directed treatment plan along with an assessment of the injured worker's functioning. It is not necessary to include the goal-directed treatment plan in each progress report unless there have been changes in the treatment plan.

Example progress note

Diagnosis: Depression, Major, single episode (296.2)

Measurements

- Physical Activity
 - Goal: Within 60 days patient will have returned to his pre-injury level of activity.
 - Measurement: Patient will log hours of sleep and daily activities.
 - Interval: Patient will complete log daily; logs will be reviewed weekly.
 - · Mileposts:
 - Week 1: Patient will sleep no more than 10 hours a day by the end of the week, and will document twenty minutes of activity, daily, by the end of the week.
 - Week 2: Patient will sleep no more than 9 hours a day by the end of the week, and will have increased daily exercise to 30 minutes per day.
 - Weeks 3 through 8: Sleep will not exceed 8 hours per day; patient will exercise at least 1 hour daily.

Communication

- Goal: Decrease or eliminate anger-related return to work barriers.
- Measurement: Patient response to scenarios that currently cause patient to become angry and poorly communicative.
- Interval: Will be assessed at each counseling session.
- · Mileposts:
 - By week 4, patient will be able to verbalize the reasons for his anger.
 - By week 8, patient will be able to remain appropriately communicative in employment situations that currently evoke angry outbursts.

Return to Work

- Goal: Within 90 days patient will return to work full time.
- Measurement: Patient completes gradual return to work plan.
- Interval: Patient's progress will be assessed monthly.
- Mileposts:
 - Month 1: By the end of the first month of treatment, patient will have returned to work part time 4 hours a day with restricted duties.
 - Month 2: By the end of the second month of treatment, patient will have returned to work part time 6 hours a day and assumed normal duties.
 - Month 3: By the end of the third month of treatment, patient will have return to work full time.

Assessment: Since the last visit, patient has returned to light duty 4 hours a day. He reports an improvement in sleep with the increase in the dose of his antidepressant; he now feels rested after 8 hours of sleep. He is now exercising one hour a day, and is participating in household activities such as cutting the lawn with a power mower. He reports that on weekends he and his wife walk their dog for about one hour each day. Patient has met the physical activity and vocational rehabilitation goals for this period.

NON-COVERED AND BUNDLED PSYCHIATRIC SERVICES

The following services are not covered:

CPT® Code

90802, 90810-90815,	
90823-90829 and 9085	7
90845	
90846	
90849	
90845 90846	7

The following services are bundled and are not payable separately:

CPT® Code

90885	
90887	
90889	

PSYCHIATRIC CONSULTATIONS AND EVALUATIONS

All referrals for psychiatric care require prior authorization (see WAC 296-21-270). This requirement includes referrals for psychiatric consultations and evaluations.

When an authorized referral is made to a psychiatrist, the psychiatrist may bill either the E/M consultation codes or the psychiatric diagnostic interview examination code.

When an authorized referral is made to a clinical psychologist for an evaluation, the psychologist may bill only CPT® code 90801.

Authorization for CPT[®] code 90801 is limited to one occurrence every six months, per patient. per provider.

Refer to WAC 296-20-045 and WAC 296-20-051 for more information on consultation requirements.

Telephonic psychology services are not covered. Refer to the Teleconsultation Section for further details.

CASE MANAGEMENT SERVICES

Psychiatrists and clinical psychologists may only bill for case management services when providing consultation or evaluation.

Refer to Case Management Services in the Evaluation and Management section for payment criteria and documentation requirements for case management services.

INDIVIDUAL INSIGHT ORIENTED PSYCHOTHERAPY

Individual insight oriented psychotherapy services are divided into services with an E/M component and services without an E/M component. Coverage of these services is different for psychiatrists and clinical psychologists.

Psychiatrists may bill individual insight oriented psychotherapy codes (CPT[®] 90804-90809, 90816-90819, 90821-90822) either with or without an E/M component. Psychotherapy with an E/M component may be billed when services such as medical diagnostic evaluation, drug management, writing physician orders and/or interpreting laboratory or other medical tests are conducted along with psychotherapy treatment.

Clinical psychologists may bill only the individual insight oriented psychotherapy codes without an E/M component. They may not bill psychotherapy with an E/M component because medical diagnostic evaluation, drug management, writing physician orders and/or interpreting laboratory or other medical tests are outside the scope of clinical psychologist licensure.

Further explanation of this policy and CMS's response to public comments about it are published in Federal Register Volume 62 Number 211, issued on October 31, 1997. The Federal Register is available on line at http://www.gpoaccess.gov/fr/index.html.



To report individual psychotherapy, use the time frames in the CPT® code descriptions for each unit of service. When billing these codes, do not bill more than one unit per day. When the time frame is exceeded for a specific code, bill the code with the next highest time frame.

USE OF CPT® EVALUATION AND MANAGEMENT CODES FOR PSYCHIATRIC OFFICE VISITS

Psychologists may not bill the E/M codes for office visits.

Psychiatrists may not bill the E/M codes for office visits on the same day psychotherapy is provided for the same patient. If it becomes medically necessary for the psychiatrist to provide an E/M service for a condition other than that for which psychotherapy has been authorized, the provider must submit documentation of the event and request a review before payment can be made.

PHARMACOLOGICAL EVALUATION AND MANAGEMENT

Pharmacological evaluation is payable only to psychiatrists. If a pharmacological evaluation is conducted on the same day as individual psychotherapy, the psychiatrist must bill the appropriate psychotherapy code with an E/M component. The psychiatrist must not bill the individual psychotherapy code and a separate E/M code in this case (CPT® codes 99201-99215). No payment will be made for psychotherapy and pharmacological management services performed on the same day, by the same physician, on the same patient.

HCPCS code M0064 is not payable in conjunction with CPT® code 90862 or with a CPT® E/M office visit or consultation code (CPT® codes 99201-99215, 99241-99275). The description for HCPCS code M0064 is "Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in treatment of mental psychoneurotic and personality disorders." It will only be payable if these described conditions are accepted or treatment is temporarily allowed by the insurer.

NEUROPSYCHOLOGICAL TESTING

The following three codes may be used if appropriate when performing neuropsychological evaluation. Reviewing records and/or writing and submitting a report is included in these codes and may not be billed separately.

CPT® Code

Billing Restriction

90801	May be billed only once every six months per patient per provider.
96101 and 96102	May be billed up to a combined four hour maximum. May be billed in addition to CPT® codes 96118 and 96119.
96118 and 96119	May be billed per hour up to a combined twelve hour maximum.

GROUP PSYCHOTHERAPY SERVICES

Group psychotherapy treatment is authorized on an individual case-by-case basis only. If authorized, the injured worker may participate in group therapy as part of his or her individual treatment plan. The insurer does not pay a group rate to providers who conduct psychotherapy exclusively for groups of injured workers.

If group psychotherapy is authorized and performed on the same day as individual insight oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions.

NARCOSYNTHESIS AND ELECTROCONVULSIVE THERAPY

CPT® codes 90865 and 90870 require prior authorization. Authorized services are payable only to psychiatrists because they require the administration of medication.

OTHER MEDICINE SERVICES

BIOFEEDBACK

Biofeedback treatment requires an attending doctor's order and prior authorization. Refer to WAC 296-20-03001 for information on what to include when requesting authorization. Rental of home biofeedback devices are time limited and require prior authorization. Refer to WAC 296-20-1102 for the insurers' policy on rental equipment.

The extent of biofeedback treatment is limited to those procedures allowed within the scope of practice of the licensed and approved biofeedback provider administering the service.

WAC 296-21-280 limits provision of biofeedback to those practitioners who are either certified by the Biofeedback Certification Institute of America (BCIA) or who meet the certification requirements. The WAC also sets forth authorization conditions, treatment limitations and reporting requirements for biofeedback services.

Anyone who is a qualified or certified biofeedback provider as defined in

WAC 296-21-280, but is not licensed as a practitioner as defined in WAC 296-20-01002, may not receive direct payment for biofeedback services. These persons may perform biofeedback as paraprofessionals as defined in WAC 296-20-015 under the direct supervision of a qualified, licensed practitioner whose scope of practice includes biofeedback and who is BCIA certified or who meets the certification qualifications. The supervising licensed practitioner must bill the biofeedback services.

When biofeedback is performed in conjunction with individual psychotherapy, use either CPT[®] code 90875 or 90876do not bill CPT[®] codes 90901 or 90911 with the individual psychotherapy codes.

The following table contains the biofeedback codes payable to approved providers:

CPT®/HCPCS

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Payable to:

90875	Department approved biofeedback providers who are:
90876	Clinical Psychologists or Psychiatrists (MD or DO).
90901 ⁽¹⁾	Any department approved biofeedback provider
90911 ⁽¹⁾	
E0746	DME or pharmacy providers (for rental or purchase). Use of the device in the office is not separately payable for RBRVS providers.

(1) CPT® codes 90901 and 90911 are not time limited and only one unit of service per day is payable, regardless of the length of the biofeedback session or number of modalities. Use appropriate evaluation and management codes for diagnostic evaluation services.

ELECTROMYOGRAPHY (EMG) SERVICES

Payment for needle electromyography (EMG) services is limited as follows:

CPT®	
Code	Limitations
95860	Extremity muscles innervated by 3 nerves or 4
95861	spinal levels must be evaluated with a minimum
95863	of 5 muscles studied.
95864	Not payable with CPT [®] code 95870
95869	 May be billed alone (for thoracic spine studies only) Limited to one unit per day For this to pay with extremity codes, test must be for T3-T11 areas only; if only T1 or T2 are studied it is not payable separately.
95870	 Limited to one unit per extremity and one unit for cervical or lumbar paraspinal muscles regardless of the number of levels tested. Not payable with extremity codes (5 units maximum payable)

ELECTROCARDIOGRAMS (EKG)

Separate payment is allowed for electrocardiograms (CPT® codes 93000, 93010, 93040 and 93042) when an interpretation and report is included. These services may be paid in conjunction with office services. EKG tracings without interpretation and report (CPT® codes 93005 and 93041) are not payable in addition to office services.

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code R0076) is bundled into the EKG procedure and is not separately payable.

EXTRACORPOREAL SHOCKWAVE THERAPY (ESWT)

The department does not cover extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature. Additional information can be found at http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/SpecCovDec/default.asp.

VENTILATOR MANAGEMENT SERVICES

No payment will be made for ventilator management services (CPT® codes 94656, 94657, 94660 and 94662) when an E/M service (CPT® codes 99201-99499) is reported on the same day by the same provider. Providers will be paid for either the appropriate ventilation management code or the E/M service, but not both. If a provider bills a ventilator management code on the same day as an E/M service, payment will be made for the E/M service and not for the ventilator management code.

MEDICATION ADMINISTRATION

Immunizations

Refer to WAC 296-20-03005 for authorization and requirements for work-related exposure to an infectious disease. Immunization materials are payable when authorized. CPT® codes 90471 and 90472 are payable in addition to the immunization materials code(s). Add-on CPT® code 90472 is limited to a maximum of one unit per day. An E/M code is not payable in addition to the immunization administration service, unless it is performed for a separately identifiable purpose and billed with a -25 modifier. Refer to Testing for and Treatment of Bloodborne Pathogens in the Pathology and Laboratory Services section and Provider Bulletin 01-06 for the department's policy on post-exposure prophylaxis for bloodborne pathogens.

Immunotherapy

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. Complete service codes will not be paid. The provider must bill as appropriate, one of the injection codes and one of the antigen/antigen preparation codes.

Infusion Therapy Services and Supplies for RBRVS Providers

Prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic or home, regardless of who performs the service.

Exception: Outpatient infusion therapy services are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. In these situations, infusion therapy services (CPT® codes 90760, 90761, 90765-90768) are payable to physicians, ARNPs, and PAs. Intravenous or intra-arterial therapeutic or diagnostic injection codes (CPT® codes 90773 and 90774) will not be paid separately in conjunction with the IV infusion codes.

Durable Medical Equipment (DME) Providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account number.

Refer to the Home Health Services section for further information on home infusion therapy.

Providers will be paid for E/M office visits in conjunction with infusion therapy only if the services provided meet the service code definitions.

Billing instructions for non-pharmacy providers are located in Injectable Medications later in this section. Drugs supplied by a pharmacy must be billed on pharmacy forms with national drug codes (NDCs or UPCs if no NDC is available).

Infusion therapy supplies and related durable medical equipment such as infusion pumps are not separately payable for RBRVS providers. Payment for these items is bundled into the fee for the professional service. If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the Home Health Services section for further information.

The department does **not** routinely cover implantable infusion pumps and supplies (HCPCS codes A4220, E0782, E0783, E0785 and E0786). The department also does not routinely cover the implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal.

NOTE: When a spinal cord injury is an accepted condition, the insurer may authorize payment for anti-spasticity medications by any indicated route of administration (e.g., some benzodiazepines, Baclofen). Prior authorization is required.

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of medications is covered.

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material are not covered (see WAC 296-20-03002).

Infusion of any opiates and their derivatives (natural, synthetic or semi-synthetic) are not covered unless they are part of providing anesthesia, short term post operative pain management (up to 48 hours post discharge), or unless medically necessary in emergency situations (see WAC 296-20-03014).

Therapeutic or Diagnostic Injections

Professional services associated with therapeutic or diagnostic injections (CPT[®] code 90772) are payable along with the appropriate HCPCS "J" code for the drug. E/M office visit services provided on the same day as an injection may be payable if the services are separately identifiable. Separate E/M services (CPT® codes 99212-99215) may be billed using a -25 modifier. CPT[®] code 99211 will not be paid separately and, if billed with the injection code, providers will be paid only the E/M service and the appropriate HCPCS "J" code for the drug. Providers must document the name, strength, dosage and quantity of the drugs administered in the medical record and in the remarks section on the bill.

Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes 90773 and 90774) may be billed separately and are payable if they are not provided in conjunction with IV infusion therapy services (CPT[®] codes 90760, 90761, 90765-90768).

NOTE: Injections of narcotics or analgesics are not permitted or paid in the outpatient setting except on an emergency basis (see WAC 296-20-03014) or for pain management related to outpatient surgical procedures and dressing and cast changes for severe soft tissue injuries, burns or fractures.

Dry needling is considered a variant of trigger point injections with medications. Dry needling is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. The department does not cover acupuncture services (see WAC 296-20-03002). Dry needling of trigger points must be billed using CPT® codes 20552 and 20553. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(14).

Injectable Medications

Providers must use the "J" codes for injectable drugs that are administered during an E/M office visit or other procedure. The "J" codes are not intended for self-administered medications.

When billing for a non-specific injectable drug, the name, strength, dosage and quantity of drug administered or dispensed must be noted on the bill as well as documented in the medical record.

Providers must bill their acquisition cost for the drugs. Department fees for injectable medications are based on the AWP. Payment is made according to the published fee schedule amount, or the billed charge for the covered drug(s), whichever is less.

Hyaluronic Acid for Osteoarthritis of the Knee

Hyaluronic acid injections are indicated only for osteoarthritis of the knee. Other uses are considered experimental, and therefore will not be paid (see WAC 296-20-03002(6)).

Hyaluronic acid injections must be billed with CPT® code 20610 and the appropriate HCPCS code (J7320 for Synvisc injections or J7317 for Hyalgan or Supartz injections).

The correct side of body modifier (-RT or -LT) is required for authorization and billing. If bilateral procedures are required, both modifiers must be authorized and each must be billed as a separate line item.

See Coverage Decisions for Medical Technologies and Procedures at http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/SpecCovDec/default.asp

and Technology Assessment, Hyaluronic Acid at

http://www.LNI.wa.gov/ClaimsIns/Files/OMD/Hyalgan.pdf and Provider Bulletin 04-13 for more information about the use of hyaluronic acid for osteoarthritis of the knee.

Non-Injectable Medications

Providers may administer oral or non-injectable medications during office procedures or dispense them for short-term use until the injured worker can have their prescription filled at a pharmacy. In these cases, providers must bill the distinct "J" code that describes the medication. If no distinct "J" code describes the medication, the most appropriate non-specific HCPCS code listed below must be used:

HCPCS	Brief Description	
Code		
J3535	Metered dose inhaler drug	
J7599	Immunosuppressive drug, noc	
J7699	Inhalation solution for DME	
J7799	Non-inhalation drug for DME	
J8499	Oral prescrip drug non-chemo	
J8999	Oral prescription drug chemo	

The name, strength, dosage and quantity of drug administered or dispensed must be noted on the bill as well as documented in the medical record. No payment will be made for pharmaceutical samples.

Providers must bill their acquisition cost for the drugs. See the Acquisition Cost Policy in the Supplies, Materials and Bundled Services section for more information.

OBESITY TREATMENT

Obesity does not meet the definition of an industrial injury or occupational disease. Temporary treatment of obesity may be allowed when the unrelated obesity condition hinders recovery from an accepted condition. Services for all obesity treatment require prior authorization. To be eligible for obesity treatment, the injured worker must be severely obese. Severe obesity for the purposes of providing obesity treatment is defined by the department as a Body Mass Index (BMI) of 35 or greater.

The attending doctor may request a weight reduction program if the injured worker meets all of the following criteria:

- Is severely obese; and
- Obesity is the primary condition retarding recovery from the accepted condition; and
- The weight reduction is necessary in order to undergo required surgery, or participate in physical rehabilitation, or return to work.

An attending doctor who believes a worker may qualify for obesity treatment should contact the insurer. The attending doctor will need to advise the insurer of the injured worker's weight and level of function prior to the injury and how it has changed. The attending doctor must submit medical justification for obesity treatment, including tests, consultations or diagnostic studies that support the request.

The attending doctor may request a consultation with a certified dietitian (CD) to determine if an obesity treatment program is appropriate for the injured worker. Only CDs will be reimbursed for nutrition counseling services. Providers practicing in another state that are similarly certified or licensed may apply to be considered for reimbursement. CDs that do not already have a provider number may call the Provider Hotline at 1-800-848-0811 for a provider application. CDs may bill for authorized services using CPT® code 97802 or 97803. Both CPT® 97802 and 97803 are billed in 15 minute units.

Code Limit **Maximum Fee** per unit

CPT® 97802	Initial visit, maximum of 4 units	\$ 26.57
CPT® 97803	Maximum 2 units per visit with maximum of 3 visits	\$ 26.57

Prior to authorizing an obesity treatment program, the attending doctor and injured worker will be required to develop a treatment plan and sign an authorization letter. This authorization letter will serve as a memorandum of understanding between the insurer, the injured worker and the attending doctor. The treatment plan will include:

- The amount of weight the injured worker must lose to undergo surgery.
- Estimated length of time needed for the injured worker to lose the weight.
- A diet and exercise plan, including a weight loss goal, approved by the attending doctor as safe for the injured worker.
- Specific program or other weight loss method requested.
- The attending doctor's plan for monitoring weight loss.
- Documented weekly weigh-ins.
- Group support facilitated by trained staff.
- Counseling and education provided by trained staff.
- No requirements to buy supplements or special foods.

The insurer does not pay for:

- Surgical treatments of obesity (for example, gastric stapling or jaw wiring).
- Drugs or medications used primarily to assist in weight loss.
- Special foods (including liquid diets).
- Supplements or vitamins.
- Educational material (such as food content guides and cookbooks).
- Food scales or bath scales.
- Exercise programs or exercise equipment.

Upon approval of the obesity treatment plan, the attending doctor's role is to:

- Examine the worker, monitor and document the worker's weight loss every 30 days.
- Notify the insurer when the worker reaches the weight loss goal, when obesity no longer interferes with recovery from accepted condition, or if the worker is no longer losing the agreed upon weight to meet the weight loss goal in the treatment plan.

To ensure continued authorization of the obesity treatment plan the worker must do each of the following:

- Lose an average of one to two pounds a week.
- Regularly attend weekly treatment sessions (meetings and weigh-ins).
- Cooperate with the approved obesity treatment plan.
- Be evaluated by the attending doctor at least every 30 days.
- Pay the joining fee and weekly membership fees up front and get reimbursed.

Send the insurer a copy of the weekly weigh-in sheet signed by the program coordinator every week.

The insurer does not pay the obesity treatment provider directly. The worker will be reimbursed for the obesity treatment program using the following codes:

Code **Description**

Fee Li	mits
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0440A	Weight loss program, joining fee, worker reimbursement	\$ 144.08
0441A	Weight loss program, weekly fee, worker reimbursement	\$ 28.82

The insurer authorizes obesity treatment for up to 90 days at a time as long as the injured worker does **all** of the above. The insurer stops authorizing obesity treatment when **any one** of the following occurs:

- The injured worker reaches the weight loss goal identified in the obesity treatment plan. (If the injured worker wants to continue the weight loss program for general health, the injured worker may do so at his or her own expense).
- Obesity no longer interferes with recovery from the accepted condition. (WAC 296-20-055 prohibits treatment of an unrelated condition once it no longer retards recovery from the accepted condition.)
- The injured worker is not cooperating with the approved obesity treatment plan.
- The injured worker is not losing weight at an average of one to two pounds each week.

IMPAIRMENT RATING EXAM AND REPORT BY ATTENDING DOCTORS AND CONSULTANTS

Attending doctors who are doctors of medicine, osteopathic medicine and surgery, chiropractic, podiatry and dentistry may rate impairment of their own patients. In accordance with WAC 296-23-267, doctors of naturopathy and optometry may not bill these codes. For details on this topic, please refer to the *Medical Examiners' Handbook*, page V-1. To obtain a copy or read online go to http://www.LNI.wa.gov/IPUB/252-001-000.pdf.

Attending doctors who are permitted to rate their own patients do not need to obtain an IME provider number. Attending doctors should bill using their existing provider number and should:

- Request authorization from the claim manager to ensure payment for these services.
- Perform the rating when the worker has reached maximum medical improvement (MMI).
 This generally occurs during the closing examination where you provide objective measurements. (This is crucial information for later reference if there is worsening. Claim managers will use these measurements when considering re-opening applications.)
- Submit impairment rating reports that include all of the elements of the impairment rating examination (see page V-2 of the *Medical Examiners' Handbook*.) If there is no impairment, please document that in your report.
- Use the appropriate rating system.
- Select the most appropriate billing code.

These L&I specialty codes are for use by attending doctors and consultants performing impairment ratings. Chiropractic Consultants performing impairment ratings must be on the department's list of approved examiners.

Code	Description	Maximum Fee
1190M	 Impairment rating by Attending Physician, Limited, requested by the insurer, 1 body area or organ system. Use this code if there is only 1 body area or organ system that needs to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: Familiarity with the history of the industrial injury or condition. Physical examination is directed only toward the affected body area or organ system. Diagnostic tests needed are ordered and interpreted. Impairment rating is performed as requested. Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual. 	
		\$ 409.13

Code	Description	Maximum Fee
1191M	Impairment rating by Attending Physician, Standard, requested by the insurer, 2-3 body areas or organ systems. Use this code if there are 2-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: • Familiarity with the history of the industrial injury or condition. • Physical examination is directed only toward the affected body area or	
	 organ system. Impairment rating is performed as requested. The impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. 	
	Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT [®] manual.	\$ 459.46
1192M	 Impairment Rating by Attending Physician, Complex, requested by the insurer, 4 or more body areas or organ systems. Use this code if there are 4 or more body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: Familiarity with the history of the industrial injury or condition. Physical examination is directed only toward the affected body areas or organ systems. Diagnostic tests needed are ordered and interpreted. Impairment rating is performed as requested. 	
	 Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. Office visits are considered a bundled service and are included in the 	
	impairment rating fee. Definitions of organ systems and body areas can be found in the CPT [®] manual.	\$ 574.30
1194M	Impairment Rating by consultant, Standard, requested by the insurer, 1-3 body areas or organ systems. Use this code if there are 1-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements:	
	 Records are reviewed. Physical examination is directed only toward the affected areas or organ systems of the body. Diagnostic tests needed are ordered and interpreted. 	
	 Impairment rating is performed as requested. Impairment rating report must contain the required elements noted in the Medical Examiners' Handbook. 	
	Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	\$ 459.36
1195M	Impairment Rating by Consultant, Complex, requested by the insurer, 4 or more body areas or organ systems. Use this code if there are 4 or more body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: • Records are reviewed.	
	 Physical examination is directed only toward the affected areas or organ systems of the body. Diagnostic tests needed are ordered and interpreted. Impairment rating is performed as requested. Impairment rating report must contain the required elements noted in the 	
	Medical Examiners' Handbook. Office visits are considered a bundled service and are included in the	
	impairment rating fee. Definitions of organ systems and body areas can be found in the CPT [®] manual.	\$ 574.30

Code	Description	Maximum Fee
	Impairment Rating, Addendum Report. Must be requested and authorized by the claims manager.	
	 Addendum report for additional information which necessitates review of new records. Payable to attending physician or consultant. 	
	This code is not billable when the impairment rating report did not contain all the required elements. (See the <i>Medical Examiners' Handbook</i> for the required elements.)	
		\$ 105.56

Limited, Standard and Complex Coding

The impairment rating examination should be sufficient to achieve the purpose and reason the examination was requested. Choose the code based on the number of body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s) or the condition(s) contended as work-related. Be sure the report documents the relationship of the areas examined to the accepted or contended conditions.

The definitions of body areas and organ systems from Current Procedural Terminology (CPT®) book must be used to distinguish between Limited, Standard and Complex impairment rating.

The following **body areas** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen

- Genitalia, groin, buttock
- Back
- Each extremity

The following **organ systems** are recognized:

- Eves
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Gastrointestinal
- Respiratory
- Genitourinary

- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

Note: Each extremity is counted once per extremity examined, when determining Limited, Standard or Complex codes. For example, in a case of bilateral carpal tunnel syndrome, if both right and left extremities are examined, two body areas would be counted.

Limited Example

- Injury to the little finger; physical examination is limited to the injured hand; no physical comparision to the uninjured hand is conducted or documented.
- Minor, uncomplicated burn injury with no residuals; physical examination is limited to an evaluation of the skin.

Standard Example

- Lumbar strain; physical examination includes a review of the back and lower extremities.
- Tenosynovitis of the right elbow; physical examination includes comparison of the right and left upper extremities.
- Cervical strain; physical examination includes a review of the cervical spine and upper extremities.

Complex Example

- Cervical, lumar and left shoulder strain with a contended aggravation of the right shoulder; physical examination performed on all four body areas.
- Lumbosacral and cervical strain, chest wall contusion, left knee sprain and right arm fracture; physical examination performed on all five body areas.

INDEPENDENT MEDICAL EXAMINATIONS (IME)

Only those doctors who have obtained an IME provider number can bill IME codes.

To obtain the IME provider application, go to: http://www.LNI.wa.gov/forms/pdf/245046af.pdf.

Examiners providing IMEs for Crime Victims should contact the Crime Victims Compensation Program Provider Registration desk at 360-902-5377 for application information.

If you would like more information on the requirements to become an approved IME provider or to perform impairment ratings, please see the *Medical Examiner's Handbook* or go to: http://www.LNI.wa.gov/ClaimsInsurance/Providers/IME/About.

To receive e-mail updates on this topic, subscribe to the ListServ at: http://www.LNI.wa.gov/Main/Listservs/IME.asp

IME unique billing codes

Code	Description	Maximum Fee
1100M	IME, Microfiche handling, initial 10 pages of fiche with referral.	
	Payable only once per referral.	
	You may not bill this code if you are provided with a paper copy of the claim record.	
	L&I encourages examiners to make arrangements to handle microfiche.	\$54.76
1101M	IME, Microfiche handling, per fiche page beyond 10	
	1 unit equals 1 microfiche page.	\$5.48
	Use code with associated units only once per referral.	(per fiche page)
1104M	IME, Addendum report. Requested and authorized by claims manager.	
	Addendum report for information not requested in original assignment, which necessitates review of records.	
	Not to be used for review of Job Analysis or review of diagnostic testing or	
	study results ordered by the examiner.	
		\$105.56

Code	Description	Maximum Fee
1109M	 IME, Standard exam – 1-3 body areas or organ systems Use this code if there are only 1-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). An appropriate examination and reporting of an injury or condition limited to 1-3 body areas or organ systems. Records are reviewed and the report includes a detailed chronology of the injury or condition as described in the <i>Medical Examiner's Handbook</i>. Physical examination is directed only toward the affected body areas or organ systems. Diagnostic tests needed are ordered and interpreted. Impairment rating is performed if requested. The IME report must contain the required elements noted in the Medical Examiners' Handbook. The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). Includes review of up to 2 Job Analyses. The department expects that these examinations will typically involve at least 30 minutes of face-to-face time with the patient. This code can be used by: Single examiners, Leads on multi-examiner exams where findings from other examiners are combined into 1 report, & Examiners on multi-examiner exams who perform separate file review, examination and standalone reports. Additional examiners who are not leads: Use 1112M. *** IME, Complex exam – 4 or more body areas or organ systems Use this code if there are 4 or more body areas or organ systems Use this code if there are 4 or more body areas or organ systems Records are reviewed and the report includes a detailed chronology of the injury or condition is directed only toward the affected body areas or organ systems. Diagnostic tests needed are ordered and interpreted. Impairment rating is performed if requested. The report conclusions address how the examined body areas or organ systems r	\$459.46
		\$574.30

Code **Maximum Fee** Description 1111M IME, No-show fee, per examiner. • Bill only if appointment time cannot be filled and cancellation is within 3 business days of examination. Business days are Monday thru Friday. Not payable for no-shows of IME related services (e.g. neuropsychological \$195.52 evaluations, performance based PCEs). 1112M IME-Additional examiner for IME • Use where input from more that 1 examiner is combined into 1 report. Includes: · Record review. · Examination, and Contribution to combined report Note: Lead examiner on IMEs with a combined report should bill a Standard or Complex exam code (1108M or 1109M). \$409.13 1118M IME by Psychiatrist • Psychiatric diagnostic interview with or without direct observation of a physical examination. • Includes review of records, other specialist's examination results, if any Consultation with other examiners and submission of a joint report if scheduled as part of a panel. • Report includes a detailed chronology of the injury or condition, as described in the Medical Examiner's Handbook. \$831.44 Also includes impairment rating, if applicable. 1120M IME, No-show fee – psychiatrist • Bill only if appointment time cannot be filled and cancellation is within 3 business days of examination. Business days are Monday thru Friday. Not payable for no-shows of IME related services (e.g. neuropsychological evaluations). \$303.06 1122M Impairment Rating by an approved pain program Program must be approved by the department or self-insured • Impariment rating must be requested by the insurer. Must be performed by a doctor currently licensed in medicine and surgery (including osteopathic and podiatric physicians), dentistry, or department approved chiropractic physicians. See WAC 296-20-2010. • The rating report must include at least the following elements as described in the Medical Examiners' Handbook: • MMI (maximum medical improvement) Physical exam Diagnostic tests Rating \$459.46 Rationale 1123M IME, Communication issues • Examination was unusually difficult due to expressive problems, such as a stutter, aphasia or need for a translator in a case that required an extensive history as described in the report. • Bill once per examiner per exam. • Not payable with a no-show fee (1111M or 1120M). \$184.76 1124M IME, Other, by report Requires pre-authorization and pre-pay review by Health Services By Report* Analysis. Call 360-902-6818. 1125M Physician travel per mile Allowed when roundtrip exceeds 14 miles. • Code usage is limited to extremely rare circumstances. Requires pre-authorization and pre-pay review by Health Services \$4.53 Analysis. Call 360-902-6818.

Code	Description	Maximum Fee
1128M	 Occupational disease history. Must be requested by insurer. Occupational carpal tunnel syndrome, noise-induced hearing loss, occupational dermatitis, and occupational asthma are examples of conditions which L&I considers occupational diseases. The legal standard is different for occupational diseases than for occupational injuries. This is a detailed assessment of work-relatedness, with the exact content presented in the <i>Medical Examiners' Handbook</i>. A doctor may bill this code ONLY ONCE for each patient. 	\$170.88
1129M	 IME, Extensive file review by examiner Bill for each additional page of fiche reviewed beyond the first 10 pages of microfiche OR each additional 75 hardcopy pages beyond first 750 hardcopy pages. Bill per examiner. Note Review of first 10 pages of microfiche or 750 hardcopy pages is included with the IME fee. A detailed chronology of the injury or condition is included in the report. Not payable with 1111M or 1120M. 	
		\$51.73
1130M	 IME, Terminated examination – Bill for examination ended prior to completion. Requires file review, partial examination and report (including reasons for early termination of exam). 	\$327.30
1131M	IME – Out-of-State Examination	By Report
Modifier -7N	 X-rays and laboratory services in conjunction with an IME. When X-rays, laboratory and other diagnostic tests are provided with an examination, identify the service(s) by adding the modifier – 7N to the usual procedure number. Procedure codes are listed in the L&I Fee Schedules, Radiology and Laboratory Sections. 	N/A

Billing for In-State IMEs

For IMEs performed in Washington State, Examiners need one IME provider account number for each payee they wish to designate. An IME examiner not working through any IME firms will need just one IME number, which will also serve as their payee number. If an examiner works with multiple IME firms that are identified as payees, then the examiner needs a different provider account number for each IME firm.

How IME Firms Must Bill for IMEs Conducted in WA State

The chart below summarizes which provider number to use in box 33, "PIN#" of the CMS 1500 form based on the IME service provided.

Use only the IME Examiner's Provider Number for these codes:		Use only the IME Firm Provider Number for these codes:	The following codes may be billed by the IME Examiner, the IME Firm, or by the performing provider. Only one provider may bill for the following codes:
1028M	1118M	1100M	1124M
1038M	1120M	1101M	CPT® Code 90801
1048M	1123M		CPT® Codes 96101, 96102
1066M 1125M			CPT® Codes 96118, 96119
1104M 1128M			X-ray, diagnostic laboratory tests in conjunction with IME (Use modifier -7N.)
1108M	1129M		1045M
1109M	1130M		
1111M 1112M	CPT [®] Codes 99371-99373		

NOTE: IME Firms may use their own provider number as the "payee" in all cases (box 33. under "GRP#" of the CMS 1500 form) although it is not required if the same provider number is under "PIN#".

Billing for out-of-state IMEs

- 1. A separate provider number is required for IMEs conducted outside of Washington State.
- 2. IME examiners must meet the department's criteria for approved examiners.
- 3. IME examiners must be approved by the department. To obtain the procedures and an IME Provider Application, go to http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/IME/BecomeIMEProv/.

Please be sure the application is submitted with a copy of the doctor's license for the state where the exam will be conducted and that a current curriculum vitae (CV) is attached.

- 4. Firms will not be required to put the examiner provider number on State Fund bills.
- 5. Bills for out-of-state IMEs must contain the IME firm's provider number in box 33 of the CMS 1500 bill form under "PIN#."
- 6. Bill your usual and customary fees.
- 7. Use billing code 1131M for all services, except 1100M and 1101M, and the CPT® codes for neuropsychological evaluation and testing. Combine all 1131M charges into one lineitem on your bill. Also use 1131M for activities occurring after the IME, such as addendums.
- 8. L&I and self insurers will reimburse 1131M "by report." "By report" is defined in WAC 296-20-01002, Definitions, at

http://www.lni.wa.gov/ClaimsIns/Rules/MedicalAid/Rule29620/2962001002.asp Standard and Complex Coding

The examination should be sufficient to achieve the purpose and reason the examination was requested. Choose the code based on the number of body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s) or the condition(s) contended as work-related. Be sure the report documents the relationship of the areas examined to the accepted or contended conditions..

The definitions of body areas and organ systems from Current Procedural Terminology (CPT®) book must be used to distinguish between Limited and Complex IMEs.

The following **body areas** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen

Each extremity

- The following **organ systems** are recognized:
 - Eves
 - Ears, Nose, Mouth and Throat
 - Cardiovascular
 - Gastrointestinal
 - Respiratory
 - Genitourinary

Musculoskeletal

• Genitalia, groin, buttock

Skin

Back

- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

Note: Each extremity is counted <u>once per extremity examined</u>, when determining Standard or Complex codes. For example, in a case of bilateral carpal tunnel syndrome, if both right and left extremities are examined, two body areas would be counted.

Standard Example

- Lumbar strain; physical examination includes a review of the back and lower extremities.
- Tenosynovitis of the right elbow; physical examination includes comparison of the right and left upper extremities.
- Cervical strain; physical examination includes a review of the cervical spine and upper extremities.

Complex Example

- Cervical, lumbar and left shoulder strain with a contended aggravation of the right shoulder; physical examination performed on all four body areas.
- Lumbosacral and cervical strain, chest wall contusion, left knee sprain and right arm fracture; physical examination performed on all five body areas.

NATUROPATHIC PHYSICIANS

Naturopathic physicians must use the E/M CPT® codes to bill for office visit services, CPT® codes 99361-99373 to bill for case management services and the appropriate HCPCS codes to bill for miscellaneous materials and supplies.

USE OF CPT® EVALUATION AND MANAGEMENT CODES FOR NATUROPATHIC OFFICE VISITS

Naturopathic physicians may bill the first four levels of CPT® new and established patient office visit codes. The department uses the CPT® definitions for new and established patients. If a provider has treated a patient for any reason within the last three years, the person is considered an established patient. Refer to a CPT® book for complete code descriptions, definitions and guidelines.

Refer to Case Management Services in the Evaluation and Management section for payment criteria and documentation requirements for case management services.

The department will not pay naturopathic physicians for services that are not specifically allowed. Refer to Chapter 296-23 WAC for additional information.

PATHOLOGY AND LABORATORY SERVICES

PANEL TESTS

Automated Multichannel Tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both.

The following tests are automated multichannel tests or panels comprised solely of automated multichannel tests:

CPT [®] codes								
80048	80069	82247	82374	82550	82977	84100	84295	84478
80051	80076	82248	82435	82565	83615	84132	84450	84520
80053	82040	82310	82465	82947	84075	84155	84460	84550

Payment Calculation for Automated Tests

The automated individual and panel tests above will be paid based on the total number of unduplicated automated multichannel tests performed per day per patient. Payment calculation is made according to the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined;
- The CPT[®] codes for each test in the panel are compared to any individual tests billed separately for that day;
- Any duplicated tests are denied;
- Then the total number of remaining unduplicated automated tests is counted. See the following table to determine the payable fee based on the total number of unduplicated automated tests performed:

Numbe	r of Tests	Fee
1	Test	Lower of the single test or \$10.19
2	Tests	\$10.19
3 –12	Tests	\$12.50
13 –16	Tests	\$16.69

Numbe	er of Tests	Fee
17 – 18	Tests	\$18.70
19	Tests	\$21.63
20	Tests	\$22.33
21	Tests	\$23.03
22 –23	Tests	\$23.73

Payment Calculation for Panels with Automated and Non-Automated Tests

When panels are comprised of both automated multichannel tests and individual non-automated tests, they will be priced based on:

- The automated multichannel test fee based on the number of tests, added to
- The sum of the fee(s) for the individual non-automated test(s).

For example CPT[®] code 80061 is comprised of two automated multichannel tests and one non-automated test. As shown below, the fee for 80061 is **\$26.21**.

CPT [®] 80061 Component Tests	Number of Automated Tests	Maximum Fee
Automated: CPT [®] 82465 CPT [®] 84478	2	Automated: \$ 10.19
Non-Automated: CPT® 83718		Non-Automated: \$ 16.02
MAXIMUM PAYMENT:		\$ 26.21

Payment Calculation for Multiple Panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be limited to the total fee allowed for the unduplicated component tests.

Example:

The table below shows how the maximum payment would be calculated if panel codes 80050, 80061 and 80076 were billed with individual test codes 82977, 83615, 84439 and 85025.

Test	CPT® PANEL CODES		INDIVIDUAL	Test Count	Max Fee	
	80050	80061	80076	TESTS		
Automated Tests	82040 84075 82247 84132 82310 84155 82374 84295 82435 84450 82565 84460 82947 84520	82465 84478	82040 ⁽¹⁾ 82247 ⁽¹⁾ 82248 84075 ⁽¹⁾ 84155 ⁽¹⁾ 84450 ⁽¹⁾ 84460 ⁽¹⁾	82977 83615	19 Unduplicated Automated Tests	\$ 21.63
Non-Automated Tests	84443 85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009	83718	None	84439 85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009 ⁽¹⁾		\$ 32.75 \$ 15.20 \$ 16.02 \$ 17.11 \$ 0.00
MAXIMUM PAYMENT:					\$ 81.08	

(1) Duplicated tests

REPEAT TESTS

Additional payment will be allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) must be taken from separate encounters. Test(s) normally performed in a series (e.g., glucose tolerance tests or repeat testing of abnormal results) do not qualify as separate encounters. The medical necessity for repeating the test(s) must be documented in the patient's record.

Modifier –91 must be used to identify the repeated test(s). Payment for repeat panel tests or individual components tests will be made based on the methodology described above.

SPECIMEN COLLECTION AND HANDLING

Specimen collection charges are allowed for provider or practitioner, independent laboratory or outpatient hospital laboratory services as follows:

- The fee is payable only to the provider (practitioner or laboratory) who actually draws the specimen.
- Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee who is qualified to do specimen collection performs the draw.
- Payment for performing the test is separate from the specimen collection fee.
- Costs for media, labor and supplies (e.g., gloves, slides, antiseptics, etc.) are included in the specimen collection.
- A collection fee is not allowed when the cost of collecting the specimen(s) is minimal, such
 as a throat culture, Pap smear or a routine capillary puncture for clotting or bleeding time.
- No fee is payable for specimen collection performed by patients in their homes (such as stool sample collection).



Use CPT[®] code 36415 for venipuncture. Use HCPCS code P9612 or P9615 for catheterization for collection of specimen.

Complex vascular injection procedures, such as arterial punctures and venisections, are not subject to this policy and will be paid with the appropriate CPT® or HCPCS codes.

No payment for travel will be made to nursing home or skilled nursing facility staff who perform the specimen collection. Travel will be paid in addition to the specimen collection fee when $\underline{\mathbf{all}}$ of the following conditions are met:

- It is medically necessary for a provider, practitioner or laboratory technician to draw a specimen from a nursing home, skilled nursing facility or homebound patient, and
- The provider, practitioner or lab technician personally draws the specimen, and
- The trip is solely for the purpose of collecting the specimen.

If the specimen draw is incidental to other services, no travel is payable.



Use HCPCS code P9603 to bill for actual mileage (one unit equals one mile). HCPCS code P9604 is not covered.

Payment will not be made for handling and conveyance, e.g., shipping or messenger or courier service of specimen(s). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These services are considered to be integral to the testing process and are bundled into the total fee for the testing service.

STAT LAB FEES

Usual laboratory services are covered under the Professional Services Fee Schedule. In cases where laboratory tests are appropriately performed on a STAT basis, the provider may bill HCPCS code S3600 or S3601. Payment is limited to one STAT charge per episode (not once per test). Tests ordered STAT should be limited to only those that are needed to manage the patient in a true emergency situation. The laboratory report should contain the name of the provider who ordered the STAT test(s). The medical record must reflect the medical necessity and urgency of the service.

The STAT charge will only be paid with the tests listed below.

CPT [®] Code	CPT [®] Code	CPT® Code	CPT [®] Code
80048	81003	84100	85396
80051	81005	84132	85610
80069	82003	84155	85730
80076	82009	84157	86308
80100	82040	84295	86367
80101	82055	84302	86403
80156	82150	84450	86880
80162	82247	84484	86900
80164	82248	84512	86901
80170	82310	84520	86920
80178	82330	84550	86921
80184	82374	84702	86922
80185	82435	85004	86923
80188	82550	85007	86971
80192	82565	85025	87205
80194	82803	85027	87210
80196	82945	85032	87281
80197	82947	85046	87327
80198	83615	85049	87400
81000	83663	85378	89051
81001	83874	85380	
81002	83880	85384	

HCPCS Code	Abbreviated Description	
G0306	Complete CBC, auto w/diff	
G0307	Complete CBC, auto	

TESTING FOR AND TREATMENT OF BLOODBORNE PATHOGENS

The insurer may pay for post-exposure treatment whenever an injury or probable exposure occurs and there is a potential exposure to an infectious disease. Authorization of treatment in cases of probable exposure (not injury) does not bind the insurer to subsequent allowance of a claim.

The exposed worker must apply for benefits (submit the appropriate accident report form) before the insurer can pay for testing and treatment protocols.

Covered Testing Protocols

Testing for Hepatitis B, C and HIV should be done at the time of exposure and at 3, 6, and 12 months post exposure. The following test protocols are covered.

Hepatitis B (HBV)

- HbsAg (hepatitis B surface antigen).
- Anti-HBc or HBc-Ab (antibody to hepatitis B core antigen).
- Anti-HBs or HBs-Ab (antibody to hepatitis B surface antigen).

Hepatitis C (HCV)

- Enzyme immunoassay (EIA).
- Recombinant Immunoblot Assay (RIBA).
- Strip Immunoblot Assay (SIA).

The Qualitative reverse transcriptase polymerase chain reaction (RT-PCR) test is the only way to determine whether or not one has active HCV.

The following tests are covered services once HCV is an accepted condition on a claim.

- Quantitative reverse transcriptase polymerase chain reaction (RT-PCR).
- Branched-chain DNA (bDNA).
- Genotyping.
- Liver Biopsy.

ΗIV

Two blood tests are needed to verify the presence of HIV in blood, a Rapid HIV or Enzyme Immunoassay test, and a Western Blot test to confirm seropositive status. The following tests are used to determine the presence of HIV in blood.

- Rapid HIV Test.
- Enzyme Immunoassay Test (EIA).
- Western Blot Test.
- Immunofluorescent Antibody.

The following tests are covered services once HIV is an accepted condition on a claim.

- HIV Antiretroviral Drug Resistance Testing.
- Blood Count, Kidney, and Liver Function Tests.
- CD4 Count.
- Viral Load Testing.

Post-exposure prophylaxis for HBV

Treatment with hepatitis B immune globulin (HBIG) and the hepatitis B vaccine may be appropriate.

Post-exposure prophylaxis for HIV

When a possible exposure to HIV occurs, the insurer will pay for chemoprophylaxis treatment in accordance with the most recent Public Health Services (PHS) Guidelines. Prior authorization is not required.

When chemoprophylaxis is administered, the insurer will pay for drug toxicity monitoring including complete blood count and renal and hepatic chemical function tests at baseline and periodically during drug treatment.

Covered bloodborne pathogen treatment regimens

Chronic hepatitis B (HBV)

- Interferon alfa-2b.
- Lamivudine.

Hepatitis C (HCV) - acute

- Mono Therapy.
- Combination Therapy.

HIV/AIDS: Covered services are limited to those within the most recent guidelines issued by the HIV/AIDS Treatment Information Service (ATIS). These guidelines are available on the web at http://aidsinfo.nih.gov.

Treating a reaction to testing or treatment of an exposure

The department will allow a claim and accident fund benefits when an injured worker has a reaction to covered treatment for a possible or probable exposure.

Bloodborne Pathogen Billing Codes

Diagnostic Test/Procedure

CPT [®] Code
47100
83890
83894
83896
83898
83902
83912
86689
86701
86704
86706

CPT [®] Code
86803
86804
87340
87390
87521
87522
87901
87903
87904
_

Treatment Related Procedures

CPT® Code
78725
86360
87536
80076
90371
90746 (adult)
90772-90779

CPT [®] Code
99201-99215
99217-99220

PHARMACY SERVICES

PHARMACY FEE SCHEDULE

Payment for drugs and medications, including all oral non-legend drugs, will be based on the pricing methodology described below. Refer to WAC 296-20-01002 for definitions of AWP and BLP.

The department's outpatient formulary can be found in **Appendix G** at the end of this document.

Drug Type	Payment Method
Generic	The lesser of BLP or AWP less 10%
	Plus (+)
	\$ 4.50 Professional Fee
Brand with Generic Equivalent	The lesser of BLP or AWP less 10%
(Substitution Allowed)	Plus (+)
	\$ 3.00 Professional Fee
Brand with Generic Equivalent	AWP less 10%
(Dispensed as Written)	Plus (+)
	\$ 4.50 Professional Fee
Single or multi-source brand name drugs	AWP less 10%
	Plus (+)
	\$ 4.50 Professional Fee

Compounded prescriptions will be paid at the allowed cost of the ingredients plus a compounding time fee of \$4.00 per 15 minutes and a \$4.50 professional fee.

Orders for over-the-counter non-oral drugs or non-drug items must be written on standard prescription forms. These items are to be priced on a 40% margin.

Prescription drugs and oral or topical over-the-counter medications are nontaxable (RCW 82.08.0281).

EMERGENCY CONTRACEPTIVES AND PHARMACIST COUNSELING

The department covers Emergency Contraceptive Pills (ECPs) and associated pharmacist counseling services when <u>all</u> of the following conditions are met:

- A valid claim for rape in the workplace is established with the insurer, and
- The ECP and/or counseling service is sought by the injured worker, and
- The claim manager authorizes payment for the ECP and/or the counseling, and
- The pharmacist is approved by the Department of Health Board of Pharmacy to follow this particular protocol.

Once these conditions have been met, the dispensed medication must be billed with the appropriate NDC and the counseling service with HCPCS code S9445.

INFUSION THERAPY

Services

These services require prior authorization by the insurer.

The department will only pay home health agencies and/or independent registered nurses for infusion therapy services and/or therapeutic, diagnostic, vascular injections.

Supplies

Only pharmacies and DME suppliers, including IV infusion companies, may be paid for infusion therapy supplies. Supplies (including infusion pumps) require prior authorization and must be billed with HCPCS codes. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps. Implantable infusion pumps are not routinely covered.

Exception: When a spinal cord injury is the accepted condition the insurer may pay for an implantable pump for Baclofen. Refer to WAC 296-20-03014(6).

Drugs

Infusion therapy drugs, including injectable drugs, are payable only to pharmacies. Drugs must be authorized and billed with NDC codes or UPC codes if no NDC codes are available.

DURABLE MEDICAL EQUIPMENT (DME)

Pharmacies and DME providers must bill their "usual and customary" charge for supplies and equipment with appropriate HCPCS and local codes. Delivery charges, shipping and handling, tax and fitting fees are not payable separately. DME suppliers should include these charges in the total charge for the supply. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps.

PURCHASING OR RENTING DME

Required Modifers –NU or –RR

A modifier is always required on all HCPCS codes that are used to purchase or rent DME.

- -NU for DME that is a new purchase or
- **-RR** for DME that is rented.

The HCPCS Section of the Professional Services Fee Schedule provides a listing of the 'E' HCPCS codes and the limited number of 'K' HCPCS codes that require either a –NU or –RR. Look in the HCPCS/CPT® code column of the fee schedule for the appropriate modifier.

DME codes fall into one of three groups relative to modifier usage:

- DME that is only purchased by the department (only –NU modifier allowed).
- DME that is only rented by the department (only –RR modifier allowed).
- DME that can be either purchased or rented by the department (either –NU or –RR modifier allowed).

Bills submitted without the correct modifier will be denied payment. Providers may continue to use other modifiers, e.g. LT, RT etc in conjunction with the mandatory modifiers if appropriate (up to four modifiers may be used on any one HCPCS code).

Exception: HCPCS code E1340 (Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes) does not require a modifier.

The department will not purchase used equipment.

DME Rental

DME that is rented must have the –RR modifier. The rental codes with their appropriate modifier can be found in HCPCS Section of the Professional Services Fee Schedule.

Rental payments will not exceed 12 months. At the 12th month of rental, the equipment is owned by the injured worker. The insurer may review rental payments at 6 months and decide to purchase the equipment at that time. DME that is purchased belongs to the injured worker.

The maximum allowable rental fee is based on a per month period. One month or less of rental is equal to one unit of service.

Exception: HCPCS E0935, Passive motion exercise device is rented on a per diem basis with one unit of service equaling one day.



If the equipment is being rented for one day, use the same date for the first and last dates of service.

If the equipment is being rented for more than one day, do not use the same date for first and last dates of service, use the actual dates.

Errors will ultimately result in suspension and/or denial of payment of the bill and any subsequent bills.

Some equipment will only be rented by the insurer.

- These normally are extremely high cost items or items that are only utilized for short duration.
- Examples of these items are: E0118, E0193, E0194, E0277, E0935, E1800-E1818, E1825 and E1830.

DME Purchase After Rental

Equipment rented for less than 12 months and permanently required by the injured worker:

- The provider will retrieve the rental equipment and replace it with the new DME item.
- The provider should bill their usual and customary charge for the new replacement DME item. The HCPCS code billed will require a –NU modifier.
- The department will pay the provider the new purchase price for the replacement DME item in accordance with the established maximum fee.
- Self-insurers may purchase the equipment and receive rental credit toward the purchase.

DME, miscellaneous, E1399

HCPCS code E1399 will be paid by report.

- E1399 is payable only for DME that does not have a valid HCPCS code assigned.
- All bills for E1399 items must have either the –NU or –RR modifier.
- A description must be on the paper bill or in the remarks section of the electronic bill.
- The item must be appropriate relative to the injury or type of treatment being received by the injured worker.

OXYGEN AND OXYGEN EQUIPMENT

The department will generally follow Medicare guidelines concerning oxygen and oxygen equipment. The department primarily rents oxygen equipment and will no longer rent to purchase.

Stationary Oxygen Systems

Fee schedule payments for stationary oxygen system rentals are all-inclusive. One monthly fee is paid for a stationary oxygen system. This fee includes payment for the equipment, contents (if applicable), necessary maintenance and accessories furnished during a rental month.

If the injured worker owns a stationary oxygen system, payment will be made for contents of the stationary gaseous (E0441) or liquid (E0442) system.

Portable Oxygen Systems

Fee schedule payments for portable oxygen system rentals are all-inclusive. One monthly fee is paid for a portable oxygen system. This fee includes payment for the equipment, contents, necessary maintenance and accessories furnished during a rental month.

If the injured worker owns a portable oxygen system, payment may be made for the portable contents of the gaseous (E0443) or liquid (E0444) portable system.

The fee for oxygen contents (stationary or portable) is billed once a month, not daily or weekly. It equals one unit of service.

Oxygen Concentrators

Fee schedule payments for oxygen concentrators are all-inclusive. One monthly fee is paid for an oxygen concentrator. This fee includes payment for the equipment rental, necessary maintenance and accessories furnished during a rental month.

Oxygen Accessories

Accessories include but are not limited to: cannulas (A4615), humidifiers (E0555), masks (A4620, A7525), mouthpieces (A4617), nebulizer for humidification (E0580), oxygen conserving devices (A9900), regulators (E1353), stand/rack (E1355), transtracheal catheters (A4608), and tubing (A4616). These are included in the payment for rented systems. The supplier must provide any accessory ordered by the physician. Accessories are separately payable only when they are used with a patient-owned system.

REPAIRS AND NON-ROUTINE SERVICE

Rented Equipment Repair

Repair, non-routine service and maintenance are included as part of the monthly rental fee on DME. No additional payment will be provided.

Excludes disposable and non-reusable supplies.

Purchased Equipment Repair

Repair, non-routine service and maintenance on purchased equipment that is out of warranty will be paid by report.

In those cases where damage to a piece of DME is due to injured worker abuse, neglect or misuse, the repair or replacement is the responsibility of the injured worker. Replacement of lost or stolen DME is also the responsibility of the injured worker.

E1340 should be billed per each 15 minutes. Each 15 minutes should be represented by one unit of service in the 'Units' field.

For example, 45 minutes for a repair or non-routine service of equipment requiring a skilled technician would be billed with three (3) units of service.

Warranties

A copy of the original warranty is required on each repair service completed.

Send the copy of the warranty to Claims at

Department of Labor and Industries

PO Box 44291

Olympia, WA 98504-4291

Write the claim number in the upper right-hand corner of the warranty document.

Payment will be denied if no warranty is received or if the item is still under warranty.

DME Item Type	Required Warranty Coverage
DME purchased new, excluding disposable and non-reusable supplies	Limited to the manufacturer's warranty
Rented DME	Complete repair and maintenance coverage is provided as part of the monthly rental fee
E1230 Power operated vehicle (3- or 4-wheel non-highway) "Scooter"	Minimum of 1 year or manufacturer's warranty whichever is greater
Wheelchair frames (purchased new) and wheelchair parts	Minimum of 1 year of manufacturer's warranty whichever is greater
HCPCS codes K0004, K0005 and E1161	Lifetime warranty on side frames and cross braces

The department pays for TENS units, services and supplies under contract only. Refer to the TENS section, page 72, for more information.

For further information on miscellaneous services and appliances, refer to WAC 296-23-165.

BUNDLED CODES

Covered HCPCS codes listed as **bundled** in the fee schedules are payable to pharmacy and DME providers because there is no office visit or procedure associated with these provider types into which supplies can be bundled.

HOT AND COLD PACKS OR DEVICES

Application of hot or cold packs (CPT $^{\otimes}$ code 97010) is bundled for all providers.

Hot or cold therapy durable medical equipment (DME) is not covered.

Exception: HCPCS code E0230, Ice Cap or collar, is covered for DME Providers only.

WAC 296-20-1102 prohibits payment for heat devices for home use including heating pads. These devices are either bundled or not covered.

AUTHORIZATION REQUIREMENTS

DME bills may be denied if prior authorization is not obtained for services requiring prior authorization. Prior authorization for state fund claims can be obtained by calling the claim manager or Provider Hotline. The Provider Hotline can be reached at 1-800-848-0811 or from Olympia 902-6500.

For prior authorization on self-insured claims, contact the self-insured employer.

HOME HEALTH SERVICES

Attendant service, home health and hospice providers should use the codes listed in this section to bill for services. All of these services require prior authorization. The insurer will pay only for proper and necessary care and supplies needed because of physical restrictions caused by the industrial injury or disease. The insurer will not pay for services that are not specifically authorized.

Chore services and other services required to meet the worker's environmental needs are not covered except for home hospice care.

ATTENDANT SERVICES

Attendant services are proper and necessary personal care services provided to maintain the injured worker in his or her residence. To be covered, attendant services must be requested by the attending provider and authorized by the insurer before care begins. All attendant services must be provided through an agency that is licensed, certified or registered to provide home health or home care services. Home health and home care agencies must establish a provider account number and provide routine RN supervision. Payment for routine RN supervision and provider business overhead is not separately payable.

Exception: Spouses who provided department approved attendant services to their spouse prior to October 1, 2001 and who met department criteria prior to the end of year 2002 may continue to provide non-agency care to their spouse. Spouses are limited to 70 hours per week. Exemptions from this limit will be made based on department review.

Respite care will be allowed when non-agency spouse caregivers are unable to provide care. Injured workers and their caregivers are responsible for coordinating respite care with an agency. Respite care hours and length of services must be pre-authorized by the insurer and provided by licensed agencies. Respite care in a facility may be approved if no other appropriate caregiver can be located.

The department will determine the maximum hours of authorized attendant services based on an independent nursing assessment of the worker's care needs. Self-insurers may use other methods to determine care needs.

The insurer will notify the provider and worker in writing if current, approved hours are modified or changed based on independent nursing evaluations of proper and necessary care.

Refer to WAC 296-20-091 and WAC 296-23-246 for additional information.

Covered Services

The insurer will approve hours of care based on an independent nursing evaluation. The following are examples of covered home health care services:

- Administration of medications
- Assistance with basic range of motion exercises
- Bathing and personal hygiene
- Bowel and incontinent care
- Dressing
- Feeding assistance (not meal preparation)
- Mobility assistance including walking, toileting and other transfers
- Respite care when approved in advance.
- Specialized skin care including caring for or changing dressings or ostomies
- Tube feeding
- Turning and positioning

Non-Covered Services

Chore services and other services required to meet the worker's environmental needs are not covered. The following services are considered to be chore services:

- Childcare
- Laundry and other housekeeping activities
- Meal planning and preparation
- Other everyday environmental needs unrelated to the medical care of the injured worker
- Recreational activities
- Shopping and other errands for the injured worker
- Transportation of the injured worker
- Yard work

Attendant Service Codes

Code	Description	
8901H	Attendant services by department approved spouse provider, per hour	\$ 11.90
G0156	Services of home health aide in home health setting, each 15 minutes	\$ 6.05

Additional Home Health Codes

Code	Description	Fee
8907H	Home health agency visit (RN), per day	\$ 139.00
8912H	Home health agency visit (RN), each additional visit, per day	\$ 58.45
G0151	Services of physical therapist in home health setting, each 15 minutes (1 hour limit per day)	\$ 34.74
G0152	Services of occupational therapist in home health setting, each 15 minutes (1 hour limit per day)	
G0153	Services of speech and language pathologist in home health setting, each 15 minutes (1 hour limit per day)	\$ 36.01
S9124	Nursing care, in the home by licensed practical nurse, per hour	\$ 38.44

Bundled Codes

Covered HCPCS codes which are listed as bundled in the fee schedules are separately payable to home health and home care providers for supplies used during the home health/home care visit.

Documentation

Home nursing care providers must submit the initial assessment, attending provider's treatment plan and/or orders and home care treatment plan within 15 days of beginning the service. Updated plans must be submitted every 60 days thereafter.

Nursing Evaluations

Independent nursing evaluations, when requested by the insurer, may be billed under Nurse Case Manager or Home Health Agency Visit (RN) codes, using their respective codes.

HOSPICE SERVICES

In-home hospice services must be preauthorized and may include chore services. The following code applies to in-home hospice care:

Code	Description	Fee
S9126	Hospice care, in the home, per diem	By Report

For hospice services performed in a facility, please refer to Nursing Home, Residential and Hospice Care Services in the Facility Section.

HOME INFUSION THERAPY SERVICES

Prior authorization is required for all scheduled or ongoing infusion therapy services, including any supplies and drugs provided in the home, regardless of who provides the service.

Infusion therapy drugs, including injectable drugs, are payable only to pharmacies. Drugs must be authorized and billed with National Drug Code (NDC) codes or Universal Product Code (UPC) codes if no NDC codes are available.

The rental or purchase of infusion pumps must be billed with the appropriate HCPCS codes. See WAC 296-20-1102 for additional information.

NOTE: Payment for performing home infusion therapy and injections of medication is included with the allowed payment for home health agency nursing services and may not be billed separately.

SUPPLIES, MATERIALS AND BUNDLED SERVICES

Services and supplies must be medically necessary and must be prescribed by an approved provider for the direct treatment of a covered condition.

Providers must bill specific HCPCS or local codes for supplies and materials provided during an office visit or with other office services. CPT[®] code 99070, which represents miscellaneous supplies and materials provided by the physician, will not be paid.

Under the fee schedules, some services and supply items are considered bundled into the cost of other services (associated office visits or procedures) and will not be paid separately. See WAC 296-20-01002 for the definition of bundled codes.

NOTE: Bundled codes contain the word bundled in the dollar value column in the Professional Services Fee schedule. Refer to **Appendices B and C** for lists of bundled services and supplies.

ACQUISITION COST POLICY

Supply codes without a fee listed will be paid at their acquisition cost. The acquisition cost equals:

- The wholesale cost, plus
- Shipping and handling plus
- Sales tax.

These items must be billed together as one charge. For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill but is not required.

Wholesale invoices for all supplies and materials must be retained in the provider's office files for a minimum of five years.

A provider must submit a hard copy of the wholesale invoice to the insurer when an individual supply item costs \$150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Supplies used in the course of an office visit are considered bundled and are not payable separately.

Fitting fees are bundled into the office visit or into the cost of any DME and are not payable separately.

This policy does not apply to hospital bills. Refer to the Facilities Section for the hospital acquisition, page 155 cost billing policy.



Sales tax and shipping and handling charges are not paid separately, and must be included in the total charge for the supply. An itemized statement showing net price plus tax may be attached to bills but is not required.

CASTING MATERIALS

Bill for casting materials with HCPCS codes Q4001-Q4051. No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

MISCELLANEOUS SUPPLIES

The following supplies must be billed with HCPCS Code E1399:

- Therapeutic exercise putty.
- Rubber exercise tubing.
- Anti-vibration gloves.

Bills coded with E1399 will be reviewed for payment and must meet the following criteria:

- Description of supply on the paper bill or in electronic remarks.
- No other valid HCPCS code is available for the supply.
- The supply is appropriate for treatment of the injury and/or authorized by the claim manager.

CATHETERIZATION

Separate payment is allowed for placement of a temporary indwelling catheter when performed in a provider's office and used to treat a temporary obstruction. Payment for the service is not allowed when the procedure is performed on the same day or during the postoperative period of a major surgical procedure that has a follow-up period.

For catheterization to obtain specimen(s) for lab tests, see the Pathology and Laboratory Services section, page 100.

SURGICAL TRAYS AND SUPPLIES USED IN THE PHYSICIAN'S OFFICE

The department follows CMS's policy of bundling HCPCS codes A4263, A4300 and A4550 for surgical trays and supplies used in a physician's office.

SURGICAL DRESSINGS DISPENSED FOR HOME USE

The cost for surgical dressings that are applied during a procedure, office visit or clinic visit is included in the practice expense component of the RVU (overhead) for that provider. No separate payment is allowed.

Primary and secondary surgical dressings dispensed for home use are payable at acquisition cost when **all** of the following conditions are met:

- They are dispensed to a patient for home care of a wound, and
- They are medically necessary, and
- The wound is due to an accepted work related condition.

Primary Surgical Dressings

Primary surgical dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Examples of primary surgical dressings include items such as Telfa, adhesive strips for wound closure and petroleum gauze.

Secondary Surgical Dressings

Secondary surgical dressings serve a therapeutic or protective function and secure primary dressings. Examples include items such as adhesive tape, roll gauze, binders and disposable compression material. They do not include items such as elastic stockings, support hose and pressure garments. These items must be billed with the appropriate HCPCS.

Providers must bill the appropriate HCPCS code for each dressing item, along with the local modifier –1S for each item. Surgical dressing supplies and codes billed without the local modifier –1S are considered bundled and will not be paid.

HOT AND COLD PACKS OR DEVICES

Application of hot or cold packs is bundled for all providers.

WAC 296-20-1102 prohibits payment for heat devices for home use including heating pads. These devices are either bundled or not covered (see **Appendices B, C and D and the Durable Medical Equipment section**).

AUDIOLOGY AND HEARING SERVICES

Information about the department's hearing aid services and devices reimbursement policies can also be found in Provider Bulletin 04-11. The Bulletin is available online under the 2004 section at http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp.

The following policies and requirements apply to all hearing aid services and devices.

Exception: Codes listed in the Physicians' Current Procedural Terminology (CPT®).

SELF-INSURERS

Self-insurers who have entered into contracts for purchasing hearing aid related services and devices may continue to use them. (See WAC 296-23-165 section 1(b).) Self-insurers who do not have hearing aid purchasing contracts must follow the department's maximum fee schedule and purchasing policies for all hearing aid services and devices listed in this section.

AUTHORIZATION REQUIREMENTS

Initial and Subsequent Hearing Related Services

Prior authorization must be obtained from the insurer for all initial and subsequent hearing related services, devices, supplies and accessories in accordance with WAC 296-20-03001 and WAC 296-20-1101. The department will not pay for hearing devices provided prior to authorization.

NOTE: In cases of special need, such as when the injured worker is working and a safety issue exists, the provider may be able to obtain the insurer's authorization to dispense hearing aid(s) after the doctor's examination and before the claim is accepted.

The insurer will notify the worker in writing when the claim is accepted or denied.

The authorization process for State Fund claims may be initiated by calling the claim manager or the State Fund's Provider Hotline at 1-800-848-0811 (in Olympia call 902-6500).

For self-insured claims the provider should obtain prior authorization from the self-insurer or its third party administrator. Self-insurers can contract with a provider and can require the worker to obtain hearing related services and devices through the contracted provider.

Trial Period

A 30-day trial period is the standard established by the State of Washington 18.35 RCW. During this time, the provider supplying the aids must allow workers to have their hearing aids adjusted or be returned without cost for the aids and without restrictions beyond the manufacturer's requirements (e.g., hearing aids are not damaged). Follow-up hearing aid adjustments are bundled into the dispensing fee. If hearing aids are returned within the 30-day trial period for workers covered by the State Fund, the provider must refund the hearing aid and dispensing fee.

Types of Hearing Aids Authorized

The insurer will purchase hearing aids of appropriate technology to meet the workers' needs (e.g., digital). Decision will be based on recommendations from physicians, ARNPs, licensed audiologists or fitter/dispensers. Based on current technology, the types of hearing aids purchased for most workers are digital or programmable in the ear (ITE), in the canal (ITC) and behind the ear (BTE).

The insurer may consider Completely in the Canal (CIC) aid(s) if the physician, ARNP, audiologist or fitter/dispenser documents why CIC is needed. A written professional opinion justifying CIC aids must be submitted to the insurer.

Any other types of hearing aids needed for medical conditions will be considered based on justifications from the physician, ARNP, licensed audiologist or fitter/dispenser. The department will not purchase used equipment.

Hearing Aid Quality

All hearing aid devices provided to injured workers must meet or exceed all Food and Drug Administration (FDA) standards. All manufacturers and assemblers must hold a valid FDA certificate.

Special Authorization for Hearing Aids Over \$900

If the manufacturer's invoice cost of any hearing aid exceeds \$900 including shipping and handling, contact the claim manager for special authorization, as a review may be required.

Exception: The cost of BTE ear molds does not count toward the \$900 for special authorization. Initial BTE ear molds may be billed using V5264 and replacements may be billed using V5014 with V5264.

Authorized Testing

Testing to fit a hearing aid may be done by a licensed audiologist, fitter/dispenser, qualified physician or qualified ARNP. Obtain prior authorization for subsequent testing. The department does not pay for testing after a claim has closed.

If free initial hearing screenings are offered to the public, the department will not pay for these services.

Required Documentation

The insurer will authorize hearing aids only when prescribed or recommended by a physician or ARNP and the claim for hearing loss has been allowed. State Fund claim managers use the information outlined below to decide whether an individual worker has a valid work-related hearing loss (a self-insurer or its third party administrator may use similar forms to gather information).

- Report of Accident Form.
- Employment History Hearing Loss Form (F262-013-000; F262-013-111 continuation).
- Occupational Hearing Loss Questionnaire (F262-016-000).
- Valid audiogram.
- Medical report.
- Claimant Information Form (F245-049-000).
- Medical Release Form (F262-005-000).

PAYMENT FOR AUDIOLOGY SERVICES

The insurer does not pay any provider or worker to fill out the Employment History Hearing Loss or Occupational Hearing Loss Questionnaire.

Physicians or ARNPs may be paid for a narrative assessment of work-relatedness to the hearing loss condition. Refer to the Attending Doctors Handbook table on "Other Miscellaneous Codes and Descriptions".

The insurer will pay for the cost of battery replacement for the life of an authorized hearing aid. No more than one box of batteries (40) will be paid within each 90-day period.

NOTE: Sending injured workers batteries that they have not requested and for which they do not have an immediate need is in violation of the department's rules and payment policies.

The insurer will NOT pay for any repairs including parts and labor within the manufacturer's warranty period.

Hearing Aid Parts and Supplies Paid at Acquisition Cost

Parts and supplies will be paid at acquisition cost including volume discounts (i.e., manufacturers' wholesale invoice).

- Supply items for hearing aids include tubing, wax guards, batteries and ear hooks. These can be billed within the warranty period.
- Parts for hearing aids include switches, controls, filters, battery doors and volume control
 covers. These can be billed as replacement parts only, but not within the warranty period.
- Shells ("ear molds" in HCPCS codes) and other parts can be billed separately at acquisition cost. The department does not cover disposable shells.

Hearing aid extra parts, options, circuits and switches, e.g., T-coil and noise reduction switch, can only be billed when the manufacturer does not include these in the base invoice for the hearing aid.

Batteries

Only one box of batteries (40) is authorized within each 90-day period. Providers must document the request for batteries by the injured worker and must maintain proof that the injured worker actually received the batteries.

NOTE: Sending injured workers batteries that they have not requested and for which they do not have an immediate need is in violation of the department's rules and payment policies.

Injured Worker Responsible for Devices That Are Not Medically Necessary

The insurer is responsible for paying for hearing-related services and hearing aids that are deemed medically necessary. In the event an injured worker refuses the recommendations given in his/her case and wants to purchase different hearing aids, the worker then becomes totally responsible for the purchase of the hearing aid, batteries, supplies and any future repairs.

Injured Worker Responsible for Some Repairs, Losses, Damages

Injured workers are responsible for paying for repairs and batteries to hearing aids not authorized by the insurer.

The injured worker is also responsible for non-work-related losses or damages to their hearing aid(s), e.g., worker's pet eats/chews the hearing aid, etc. In no case will the insurer cover this type of damage. In these instances, the worker will be required to buy a hearing aid consistent with current department guidelines.

After purchase and submission of the new warranty to the insurer, the insurer will resume paying for batteries and repairs following the hearing aid payment policies.

REPAIRS AND REPLACEMENTS

The provider who arranges for repairs to hearing aid(s) authorized or purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period.

Warranties

Hearing aid industry standards provide a minimum of a one-year repair warranty on most hearing devices, which includes parts and labor. Where a manufacturer provides a warranty greater than one year, the manufacturer's warranty will apply.

The manufacturer's warranty and any additional provider warranty must be submitted in hard copy to the insurer for all hearing devices and hearing aid repairs.

The warranty should include the make, model and serial number of the individual hearing aid.

Some wholesale companies' warranties also include a replacement policy to pay for hearing aids that are lost. If the hearing aid loss is covered under the warranty, the provider must honor the warranty and replace the worker's lost hearing aid without charge.

The insurer does not purchase or provide additional manufacturers' or extended warranties beyond the initial manufacturer's warranty (or any additional provider warranty).

The insurer will NOT pay for any repairs including parts and labor within the manufacturer's warranty period.

- The warranty begins on the date the hearing aid is dispensed to the worker.
- For repairs, the warranty begins when the hearing aid is returned to the worker.

Prior Authorization Required

Prior authorization is required for all billed repairs.

The insurer will repair hearing aids and devices when needed due to normal wear and tear.

- At its discretion, the insurer may repair hearing aids and devices under other circumstances.
- After the manufacturer's warranty expires, the insurer will pay for the cost of appropriate repairs for the hearing aids they authorized and purchased.
- If the aid is damaged in a work-related incident, the worker may file a new claim.

Audiologists and fitters/dispensers may be paid for providing authorized in-office repairs. Authorized in-office repairs must be billed using V5014 and V5267.

For authorization of in-office repairs or repairs by the manufacturer, or an all-make repair company, providers must submit a written estimate of the repair cost to the Provider Hotline or claim manager.

Replacement

The insurer does not provide an automatic replacement period.

Documentation that a hearing aid is not repairable may be submitted by licensed audiologists, fitter/dispensers, all-make repair companies and FDA certified manufacturers.

If only one of the binaural analog hearing aids is not repairable and if, in the professional's opinion both hearing aids need to be replaced, the provider must submit logical rationale for the claim manager's consideration.

The insurer will replace hearing aids when they are not repairable due to normal wear and tear.

- At its discretion, the insurer may replace hearing aids in other circumstances.
- Replacement is defined as purchasing a hearing aid for the worker according to the department's most current guidelines.
- The insurer may replace the hearing aid exterior (shell) when an injured worker has ear canal changes or the shell is cracked. The insurer will not pay for new hearing aids when only new ear shell(s) are needed.
- The insurer will not replace a hearing aid due to hearing loss changes, unless the new degree of hearing loss was due to continued on-the-job exposure. A new claim must be filed with the insurer if further hearing loss is a result of continued work-related exposure or injury, or the aid is lost or damaged in a work-related incident.
- The insurer will not pay for new hearing aids for hearing loss resulting from: noise exposure that occurs outside the workplace; non-work-related diseases and conditions or the natural aging process.

The worker must sign and be given a copy of the Worker Information Form (F245-049-000). The provider must submit a copy of the signed form with the replacement request.

DOCUMENTATION AND RECORD-KEEPING REQUIREMENTS

Documentation to Support Initial Authorization

Providers must keep **all** of the following information in the worker's medical records and submit a copy to the insurer:

- Name and title of referring practitioner, if applicable; and
- Complete hearing loss history, including whether the onset of hearing loss was sudden or gradual; and
- Associated symptoms including, but not limited to, tinnitus, vertigo, drainage, earaches, chronic dizziness, nausea and fever; and
- A record of whether the injured worker has been treated for recent or frequent ear infections; and
- Results of the ear examination; and
- Results of all hearing and speech tests from initial examination; and
- Review and comment on historical hearing tests, if applicable; and
- All applicable manufacturers' warranties (length and coverage) plus the make, model and serial number of any hearing aid device(s) supplied to the injured worker as original or as a replacement; and
- Original or unaltered copies of manufacturers' invoices; and
- Copy of the Worker Information Form signed by the worker and provider; and
- Invoices and/or records of all repairs.

Documentation to Support Repair

The provider who arranges for repairs to hearing aid(s) authorized or purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period.

Documentation to Support Replacement

The following information must be submitted to the insurer when requesting authorization for hearing aid replacement.

- The name and credential of the person who inspected the hearing aid; and
- Date of the inspection; and
- Observations, e.g., a description of the damage, and/or information on why the device cannot be repaired or should be replaced.

Correspondence with the Insurer

The insurer may deny payment of the provider's bill if the following information has not been received.

- Original or unaltered wholesale invoices from the manufacturer are required to show the
 acquisition cost and must be retained in the provider's office records for a minimum of 5
 years.
- A hard copy of the original or unaltered manufacturer's wholesale invoice must be submitted by the provider when an individual hearing aid, part of supply costs \$150.00 or more, or upon the insurer's request.

NOTE: Electronic billing providers must submit a hard copy of the original or unaltered manufacturer's wholesale invoice with the make, model and serial number for individual hearing aids within 5 days of bill submission.

To avoid delays in processing, all correspondence to the insurer must indicate the injured worker's name and claim number in the upper right hand corner of each page of the document.

For State Fund claims, providers are required to send warranty information to:

Department of Labor and Industries

PO Box 44291

Olympia, WA 98504-4291

ADVERTISING LIMITS

L&I frequently gets complaints about the types of advertising or unsolicited information that workers receive about hearing aids. RCW 51.36.130 discusses false, misleading or deceptive advertising or representations. The RCW is available on the web at http://www.leg.wa.gov/RCW/.

False advertising includes mailers and advertisements:

- That suggest an injured worker's hearing aids are obsolete and need replacement; and
- Do not clearly document a specific hearing aid's failure.

BILLING REQUIREMENTS

Billing for Binaural Hearing Aids

When billing the insurer for hearing aids for both ears, providers must indicate on the CMS-1500 or Statement for Miscellaneous Services form the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for each side of the body (right/left).
- Bill the appropriate HCPCS code for binaural aids.
- Only one unit of service should be billed even though two hearing aids (binaural aids) are dispensed.

NOTE: Electronic billers are to use the appropriate field for the diagnosis code and side of body, specific to their electronic billing format.

Billing for a Monaural Hearing Aid

When billing the insurer for one hearing aid, providers must indicate on the CMS-1500 or Statement for Miscellaneous Services form the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for the side of the body (right/left) affected.
- Bill the appropriate HCPCS code for monaural aid.
- Only one unit of service should be billed.

NOTE: Electronic billers are to use the appropriate field for the diagnosis code and side of body, specific to their electronic billing format

Billing for Hearing Aids, Devices, Supplies, Parts and Services

All hearing aids, parts and supplies must be billed using HCPCS codes. Hearing aids and devices are considered to be durable medical equipment and must be billed at their acquisition cost. Refer to the Acquisition Cost Policy, page 116, for more detail.

The table below indicates what services and devices are covered by practitioner type.

Practitioner Type	Service/Device
Fitter/dispenser	HCPCS codes for all hearing related services and devices
Durable Medical Equipment providers	Supply and battery codes
Physician, ARNP, Licensed Audiologist	HCPCS codes for hearing related services and devices; and CPT® codes for hearing-related testing and office calls

AUTHORIZED FEES

Dispensing Fees

Dispensing fees cover a 30-day trial period during which all aids may be returned. Also included:

- Up to four follow-up visits (ongoing checks of the aid as the wearer adjusts to it); and
- · One hearing aid cleaning kit; and
- Routine cleaning during the first year; and
- All handling and delivery fees.

Restocking Fees

The Washington State Department of Health statute (RCW 18.35.185) and rule (WAC 246-828-290) allow hearing instrument fitter/dispensers and licensed audiologists to retain \$150 or 15% of the total purchase price, whichever is less, for any hearing aid returned within the rescission period (30 calendar days). This fee is sometimes called a "restocking" fee. Insurers without hearing aid purchasing contracts will pay this fee when an injured worker rescinds their purchase agreement.

The insurer must receive form F245-050-000 or a statement signed and dated by the provider and the worker. The form must be faxed to the department at (360) 902-6252 or forwarded to the self-insurer within two business days of receipt of the signatures. The provider must submit a refund of the full amount paid by the insurer for the dispensing fees and acquisition cost of the hearing aid that was provided to the worker. The provider may then submit a bill to the insurer for the restocking fee of \$150 or 15% of the total purchase price, whichever is less. Use code 5091V. Restocking fees cannot be paid until the insurer has received the refund.

Fee Schedule

The insurer will only purchase the hearing aids, devices, supplies, parts and services described in the fee schedule.

HCPCS Code	Description	Maximum Fee
V5008	Hearing screening	\$ 69.05
V5010	Assessment for hearing aid	Bundled
V5011	Fitting/orientation/checking of hearing aid	Bundled
V5014	Hearing aid repair/modifying visit per ear (bill repair with code 5093V)	\$ 46.04
V5020	Conformity evaluation (1 visit allowed after the 30-day trial period)	Bundled
V5030	Hearing aid, monaural, body worn, air conduction	Acquisition cost
V5040	Body-worn hearing aid, bone	Acquisition cost
V5050	Hearing aid, monaural, in the ear	Acquisition cost
V5060	Hearing aid, monaural, behind the ear	Acquisition cost
V5070	Glasses air conduction	Acquisition cost
V5080	Glasses bone conduction	Acquisition cost
V5090	Dispensing fee, unspecified hearing aid	Not covered
V5100	Hearing aid, bilateral, body worn	Acquisition cost
V5110	Dispensing fee, bilateral	Not covered
V5120	Binaural, body	Acquisition cost
V5130	Binaural, in the ear	Acquisition cost
V5140	Binaural, behind the ear	Acquisition cost
V5150	Binaural, glasses	Acquisition cost
V5160	Dispensing fee, binaural	\$ 1349.23
	(includes up to one conformity eval and two follow up visits during the 30-day trial period)	
V5170	Hearing aid, cros, in the ear	Acquisition cost
V5180	Hearing aid, cros, behind the ear	Acquisition cost
V5190	Hearing aid, cros, glasses	Acquisition cost
V5200	Dispensing fee, cros (includes up to one conformity eval and two follow up visits during the 30-day trial period)	\$ 808.69
V5210	Hearing aid, bicros, in the ear	Acquisition cost
V5220	Hearing aid, bicros, behind the ear	Acquisition cost
V5230	Hearing aid, bicros, glasses	Acquisition cost
V5240	Dispensing fee, bicros (includes up to one conformity eval and two follow up visits during the 30-day trial period)	\$ 808.69
V5241	Dispensing fee, monaural hearing aid, any type (includes up to one conformity eval and two follow up visits during the 30-day trial period)	\$ 674.62
V5242	Hearing aid, analog, monaural, cic (completely in the ear canal)	Acquisition cost
V5243	Hearing aid, monaural, itc (in the canal)	Acquisition cost

V5244	Hearing aid, digitally programmable analog, monaural, cic	Acquisition cost
V5245	Hearing aid, digitally programmable, analog, monaural, itc	Acquisition cost
V5246	Hearing aid, digitally programmable analog, monaural, ite (in the ear)	Acquisition cost
V5247	Hearing aid, digitally programmable analog, monaural, bte (behind the ear)	Acquisition cost
V5248	Hearing aid, analog, binaural, cic	Acquisition cost
V5249	Hearing aid, analog, binaural, itc	Acquisition cost
V5250	Hearing aid, digitally programmable analog, binaural, cic	Acquisition cost
V5251	Hearing aid, digitally programmable analog, binaural, itc	Acquisition cost
V5252	Hearing aid, digitally programmable, binaural, ite	Acquisition cost
V5253	Hearing aid, digitally programmable, binaural, bte	Acquisition cost
V5254	Hearing aid, digital, monaural, cic	Acquisition cost
V5255	Hearing aid, digital, monaural, itc	Acquisition cost
V5256	Hearing aid, digital, monaural, ite	Acquisition cost
V5257	Hearing aid, digital, monaural, bte	Acquisition cost
V5258	Hearing aid, digital, binaural, cic	Acquisition cost
V5259	Hearing aid, digital, binaural, itc	Acquisition cost
V5260	Hearing aid, digital, binaural, ite	Acquisition cost
V5261	Hearing aid, digital, binaural, bte	Acquisition cost
V5262	Hearing aid, disposable, any type, monaural	Not covered
V5263	Hearing aid, disposable, any type, binaural	Not covered
V5264	Ear mold (shell)/insert, not disposable, any type	Acquisition cost
V5265	Ear mold (shell)/insert, disposable, any type	Not covered
V5266	Battery for hearing device	\$ 0.82
V5267	Hearing aid supply/accessory	Acquisition cost

L&I Speciality Codes	Description	Maximum Fee
5091V	Hearing aid restocking fee (the lesser of 15% of the hearing aid total purchase price or \$150 per hearing aid)	By report
5092V	Hearing aid cleaning visit per ear (one every 90 day, after the first year)	\$ 22.17
5093V	Hearing aid repair fee. Manufacturer's invoice required	By report

INTERPRETIVE SERVICES

INFORMATION FOR HEALTH CARE AND VOCATIONAL PROVIDERS

Injured workers or crime victims (insured individuals) who have limited English proficiency or sensory impairments may need interpretive services in order to effectively communicate with providers.

Interpretive services do not require prior authorization.

Under the Civil Rights Act of 1964, the health care or vocational provider will determine whether effective communication is occurring. If assistance is needed, the health care or vocational provider selects an interpreter to facilitate communication. The health care or vocational provider determines if an interpreter accompanying (whether paid or unpaid) the insured meets the communication needs. If a different interpreter is needed, the insured may be consulted in the selection process. Sensitivity to the insured's cultural background and gender is encouraged when selecting an interpreter. Refer to information at http://www.phyins.com/pi/risk/faq.html regarding use of interpretive services.

Either paid or non-paid interpreters may assist with communications. In all cases, the paid interpreter selected must meet the credentialing standards contained in this policy. Persons identified as ineligible to provide services in this policy may not be used even if they are unpaid. Please review the sections related to eligible and ineligible interpretive services providers. Persons under the age of eighteen (18) may not interpret for injured workers or crime victims.

For paid interpreters, healthcare or vocational providers or their staff must verify services on the "Interpretive Services Appointment Record" Form 245-056-000 or a similar interpreter provider's verification form which will be presented by the interpreter at the end of the appointment. Providers should also note in their records that an interpreter was used at the appointment. When a procedure requires informed consent, a credentialed interpreter should help you explain the information.

POLICY APPLICATION

This policy applies to interpretive services provided for health care and vocational services in all geographic locations to injured workers and crime victims (collectively referred to as "insured") having limited English proficiency or sensory impairment; and receiving benefits from the following insurers:

- The State Fund (L&I),
- Self-Insured Employers or
- The Crime Victims Compensation Program.

This policy does not apply to interpretive services for injured workers or crime victims for legal purposes, including but not limited to:

- Attorney appointments.
- Legal conferences.
- Testimony at the Board of Industrial Insurance Appeals or any court.
- Depositions at any level.

Payment in these circumstances is the responsibility of the attorney or other requesting party(s).

CREDENTIALS REQUIRED FOR L&I SERVICE PROVIDER NUMBER

Interpreters and translators must have an L&I provider account. To obtain an L&I interpretive services provider account number, an interpreter or translator must submit credentials using the "Submission of Provider Credentials for Interpretive Services" form F245-055-000. Credentials accepted include those listed below under "Certified Interpreter" and "Certified Translator" or "Qualified Interpreter" or "Qualified Translator".

Interpreters and translators located outside of Washington State must submit credentials from their state Medicaid programs, state or national court systems or other nationally recognized programs.

For interpretive services providers in any geographic location, credentials submitted from agencies or organizations other than those listed below may be accepted if the testing criteria can be verified as meeting the minimum standards listed below:

Interpreter test(s) consists of, at minimum:	Document translation test(s) consists of, at minimum:
A verbal test of sight translation in both English and other tested language(s); and	A written test in English and in the other language(s) tested; or
A written test in English; and	A written test and work samples demonstrating the ability to accurately translate from one specific source language to another specific target language
A verbal test of consecutive interpretation in both languages; and	
For those providing services in a legal setting, a verbal test of simultaneous interpretation in both languages	

Certified Interpreter

Interpreter who holds credentials in good standing from one or more of the following:

Agency or Organization	Credential
Washington State Department of Social and	Social or Medical Certificate, or
Health Services (DSHS)	Provisional Certificate
Washington State Administrative Office for the Courts (AOC)	Certificate
RID-NAD National Interpreter Certification (NIC)	Certified Advanced (Level 2), or
	Certified Expert (Level 3)
Registry of Interpreters for the Deaf (RID)	Comprehensive Skills Certificate (CSC), or Master Comprehensive Skills Certificate (MSC), or Certified Deaf Interpreter (CID), or Specialist Certificate: Legal (SC:L), or Certificate of Interpretation and Certificate of Transliteration (CI/CT)
National Association for the Deaf (NAD)	Level 4, or Level 5
Federal Court Interpreter Certification Test (FCICE)	Certificate
US State Department Office of Language Services	Verification letter or Certificate

Qualified Interpreter

Interpreter who holds credentials in good standing from one or more of the following:

Agency or Organization	Credential
Translators and Interpreters Guild	Certificate
Washington State Department of Social and Health Services (DSHS)	Letter of authorization as a qualified social and/or medical services interpreter including provisional authorization
Federal Court Interpreter Certification Examination (FCICE)	Letter of designation or authorization

Certified Translator

Translator who holds credentials in good standing from one or more of the following:

Agency or Organization	Credential
Washington State Department of Social and Health Services (DSHS)	Translator Certificate
Translators and Interpreters Guild	Certificate
American Translators Association	Certificate

Qualified Translator

Translator who holds credentials in good standing from one or more of the following:

Agency or Organization	Credential
A state or federal agency;	Certificate or other verification showing:
A state or federal court system;	Successful completion of an examination
Other organization including language agencies; and/or	or test of written language fluency in both English and in the other tested
An accredited academic institution of higher	language(s); and
education.	A minimum of two years experience in document translation.

Maintaining Credentials

Interpretive services providers are responsible for maintaining their credentials as required by the credentialing agency or organization. Should the interpretive services provider's credentials expire or be removed for cause or any other reason, the provider must immediately notify the insurer(s).

Credentialed Employees of Health Care and Vocational Providers

Credentialed employees of health care and vocational providers are eligible to receive payment for interpretive services under the following circumstances:

- The individual's sole responsibility is to assist patients or clients with language or sensory limitations: and
- The individual is a credentialed interpreter or translator, and
- The individual has an L&I provider account number for interpretive services.

Interpreters/Translators Not Eligible for Payment

Other persons may on occasion assist the injured worker or crime victim with language or communication limitations. These persons do not require a provider number, but also **will not be paid** for interpretive services. These persons may include but are not limited to:

- · Family members.
- Friends or acquaintances.
- The healthcare or vocational provider.
- Employee(s) of the health care or vocational provider whose primary job is not interpretation.
- Employee(s) of the health care or vocational provider whose primary job is interpretation but who is not a credentialed interpreter or translator.
- Interpreters/Translators not complying with all applicable state and/or federal licensing or certification requirements, including but not limited to, business licenses as they apply to the specific provider's practice or business.

Persons Ineligible to Provide Interpretation/Translation Services

Some persons may not provide interpretation or translation services for injured workers or crime victims during health care or vocational services delivered for their claim. These persons are:

- The worker's or crime victim's legal or lay representative or employees of the legal or lay representative.
- The employer's legal or lay representative or employees of the legal or lay representative.
- Persons under the age of eighteen (18). Note: Injured workers or crime victims using children for interpretation purposes should be advised they need to have an adult provide these services.

Persons Ineligible to Provide Interpretation/Translation Services at IME's

Under WAC 296-23-362(3), "The worker may not bring an interpreter to the examination. If interpretive services are needed, the insurer will provide an interpreter." Therefore, at Independent Medical Examinations (IME), persons (including interpreter/translator providers with account numbers) who may not provide interpretation or translation services for injured workers or crime victims are:

- Those related to the injured worker or crime victim.
- Those with an existing personal relationship with the injured worker or crime victim.
- The worker's or crime victim's legal or lay representative or employees of the legal or lay representative.
- The employer's legal or lay representative or employees of the legal or lay representative.
- Any person who could not be an impartial and independent witness.
- Persons under the age of eighteen (18).

Hospitals and other facilities may have additional requirements

Hospitals, free standing surgery and emergency centers, nursing homes and other facilities may have additional requirements for persons providing services within the facility. For example, a facility may require all persons delivering services to have a criminal background check, even if the provider is not a contractor or employee of the facility. The facility is responsible for notifying the interpretive services provider of their additional requirements and managing compliance with the facilities' requirements.

PRIOR AUTHORIZATION

Services not requiring prior authorization

Direct interpretive services (either group or individual) and mileage do not require prior authorization on open claims. Providers can check claim status with the insurer prior to service delivery.

Services prior to claim allowance are not payable except for the initial visit. If the claim is later allowed, the insurer will determine which services rendered prior to claim allowance are payable.

Only services to assist in completing the reopening application and for insured requested IME are payable unless or until a decision is made. If a claim is reopened, the insurer will determine which other services are payable.

Services requested by the insurer or requiring prior authorization

IME Intepretation services

When an IME is scheduled, the insurer will arrange for the interpretive services. Prior authorization is not required. The insured may ask the insurer to use a specific interpreter. However, only the interpreter scheduled by the insurer will be paid for IME interpretive services. Interpreters who accompany the insured, without insurer approval, will not be paid nor allowed to interpret at the IME.

IME No Shows

Authorization must be obtained prior to payment for an IME no show. For State Fund claims, contact the Central Scheduling Unit supervisor at 206-515-2799 after occurrence of IME no show. Per WAC 296-20-010(5) "No fee is payable for missed appointments unless the appointment is for an examination arranged by the department or self-insurer."

Document translation

Document translation services are only paid when performed at the request of the insurer. Services will be authorized before the request packet is sent to the translators.

COVERED AND NON-COVERED SERVICES

Covered and may be billed to the insurer.

Payment is dependent upon service limits and department policy:

- Interpretive services which facilitate language communication between the insured and a health care or vocational provider.
- Time spent waiting for an appointment that does not begin at time scheduled (when no other billable services are being delivered during the wait time).
- Assisting the insured to complete forms required by the insurer and/or health care or vocational provider.
- A flat fee for an insurer requested IME appointment when the insured does not attend.
- Translating document(s) at the insurer's request.
- Miles driven from a point of origin to a destination point and return.

Not covered and may not be billed to nor will they be paid by the insurer:

- Services provided for a denied or closed claim (except services associated with the initial
 visit for an injury or crime victim claim or the visit for the insured's application to reopen a
 claim).
- No show for any service other than an insurer requested IME (e.g., physical therapy visits).
- Personal assistance on behalf of the insured such as scheduling appointments, translating correspondence or making phone calls.
- Document translation requested by anyone other than the insurer, including the insured.
- Services provided for communication between the insured and an attorney or lay worker representative.
- Services provided for communication not related to the insured's communications with health care or vocational providers.
- Travel time and travel related expenses such as meals, parking, lodging, etc.
- Overhead costs, such as phone calls, photocopying and preparation of bills.

FEES, SERVICE DESCRIPTIONS AND LIMITS

The coverage and payment policy for interpretive services is listed below:

Code	Description	Units of Service	Maximum Fee	L&I Authorization and Limit Information
9988M	Group Interpretation Direct services time between more than one client(s) and health care or vocational provider, includes wait and form completion time, time divided between all clients participating in group, per minute	1 minute equals 1 unit of service	\$0.82 per minute	Limited to 480 minutes per day Does not require prior authorization
9989M	Individual Interpretation Direct services time between insured and health care or vocational provider, includes wait and form completion time, per minute	1 minute equals 1 unit of service	\$0.82 per minute	Limited to 480 minutes per day Does not require prior authorization
9986M	Mileage, per mile	1 mile equals 1 unit of service	State Rate	Mileage billed over 200 miles per claim per day will be reviewed Does not require prior authorization
9996M	Interpreter "IME no show" Wait time when insured does not attend the insurer requested IME, flat fee	Bill 1 unit per injured worker no show at IME	Flat fee \$49.10 Mileage to and from appointment will also be paid	Payment requires prior authorization Contact Central Scheduling Unit after no show occurs at 260-515-2799 Only 1 no show per injured worker per day

9997M	Document Translation, at insurer request	1 page equals 1 unit of service	By Report	Authorization will be documented on translation request packet. Over \$500 per	
				claim will be reviewed	

BILLING FOR INTERPRETIVE SERVICES

Interpretive services providers use the miscellaneous bill form and billing instructions.

Individual Interpretation Services

Services delivered for a single client include interpretation performed with the insured and a health care or vocational provider, form completion and wait time. Only the time spent actually delivering those services may be billed. Time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services ended. If there are breaks in service due to travel between places of service delivery, this time must be deducted from the total time billed. See the Billing Examples for further information.

Group Interpretation Services

When interpretive services are delivered for more than one person (regardless of whether all are injured workers and/or crime victims), the time spent must be pro-rated between the participants. For example, if 3 persons are receiving a one hour group physical therapy session at different stations and the interpretive services provider is assisting the physical therapist with all 3 persons, the interpretive services provider must bill only 20 minutes per person. The time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services end. See the Billing Examples for further information.

The combined total of both individual and group services is limited to 480 minutes (8 hours) per day.

IME No Show

Per WAC 296.20.010 (5) only services related to No Shows for insurer requested IMEs will be paid. The insurer will pay a flat fee for IME no show. Mileage to and from the appointment will also be paid.

Mileage and Travel

Insurers will not pay interpretive service providers travel time or for travel expenses such as hotel, meals, parking, etc.

Interpretive service providers may bill for actual miles driven to perform interpretation services for an individual client or group of clients. When mileage is for services to more than one person (regardless of whether all are injured workers and/or crime victims), the mileage must be pro-rated between all the persons served. Mileage between appointments on the same day should be split between the clients. Mileage is payable for missed or no show appointments. See the Billing Examples for further information. Mileage over 200 miles per day will be reviewed for necessity such as rare language and/or remote location.

Document Translation Services

Document translation is an insurer generated service. Payment for document translation will be made only if the service was requested by the insurer. If anyone other than the insurer requests assistance with document translation, the insurer must be contacted before services can be delivered.

Billing Examples

Example 1 – Individual Interpretive Services

Example Scenario	Time Frames	Type of Service	Code and Units to Bill
Interpreter drives 8 miles from his place of business to the location of an appointment for an insured	Not applicable	Mileage	8 units 9986M
Insured has an 8:45 AM appointment. The interpreter and insured enter the exam room at 9:00 AM. The exam takes 20 minutes. The health care provider leaves the room for 5 minutes and returns with a prescription and an order for x-rays for the insured. The appointment ends at 9:30 AM.	8:45 AM to 9:30 AM	Individual Interpretive Services	45 units 9989M
Interpreter drives 4 miles to x-ray service provider and meets insured.	Not applicable	Mileage	4 units 9986M
Interpreter and insured arrive at the radiology facility at 9:45 AM and wait 15 minutes for x-rays which takes 15 minutes. They wait 10 minutes to verify x-rays do not need to be repeated.	9:45 AM to 10:25 AM	Individual Interpretive Services	40 units 9989M
Interpreter drives 2 miles to pharmacy and meets insured.	Not applicable	Mileage	2 units 9986M
The insured and the interpreter arrive at the pharmacy at 10:35 AM and wait 15 minutes at the pharmacy for prescription. The interpreter explains the directions to the insured which takes 10 minutes.	10:35 AM to 11 AM	Individual Interpretive Services	25 units 9989M
After completing the services, the interpreter drives 10 miles to the next interpretive services appointment. The interpreter splits the mileage between the insured and the next client if this is not the last appointment of the day	Not applicable	Mileage	5 units 9986M
Total billable services for the scenario	Individual Interpretive Mileage	Services	110 units 9989M 19 units 9986M

Example 2 – Group Interpretive Services			
Example Scenario	Time Frames	Type of Service	Code and units to Bill
Interpreter drives 9 miles from his place of business to the location of an appointment for three clients. Two are insured by the state fund.	Not applicable	Mileage	3 units of 9986M to each state fund claim
The three clients begin a physical therapy appointment at 9:00 AM. The interpreter circulates between the three clients during the appointment which ends at 10 AM.	9 AM to 10 AM	Group Interpretive Services	20 units of 9988M to each state fund claim
After completing the appointment the interpreter drives 12 miles to next appointment location. The interpreter splits the mileage between the three clients and the next client if this is not the last appointment of the day (12 divided by 2=6; 6 divided by 3=2).	Not applicable	Mileage	2 units 9986M to each state fund claim
Total billable services for the scenario	Group Interpretive Se Mileage		20 units 9988M 5 units 9986M
	Billed to EACH state	tund claim	

DOCUMENTATION REQUIREMENTS

Direct interpretive services must be recorded on the L&I "Interpretive Services Appointment Record" form F245-056-000. Copies can be obtained on the department's website or a supply of forms can be ordered from the warehouse. Interpretive services providers may also use their own encounter forms to document services, meeting the criteria listed below.

Provider or agency encounter forms used in lieu of the department's Interpretive Services Appointment Record **must** have the following information:

- Claim number, claimant full name and date of injury in upper right hand corner of form.
- Interpreter name and agency name (if applicable).
- Encounter (appointment) information including:
 - Health care or vocational provider name.
 - Appointment address.
 - Appointment date.
 - Appointment start time.
 - Interpreter arrival time.
 - Appointment completion time.
 - If a group appointment, total number of clients (not health care or vocational providers) participating in the group appointment.
- Mileage Information including:
 - Miles from starting location (including street address) to appointment.
 - Miles from appointment to next appointment or return to starting location (include street address).
 - · Total miles.
- Verification of appointment by health care or vocational provider.
 - Printed name and signature of person verifying services.
 - Date signed.

NOTE: All agency encounter and Interpretive Services Appointment Record forms must be signed by the health care or vocational provider or their staff to verify services including mileage for missed appointments or IME no shows.

Documentation for translation services must include:

- Date of service
- Description of document translated (letter, order and notice, medical records)
- Total number of pages translated
- Total words translated
- Target and Source languages



Do not staple documentation to bill forms. Send documentation separately from bills for state fund or crime victims claims to:

State Fund	Crime Victims
Department of Labor and Industries	Department of Labor and Industries
PO Box 44291	PO Box 44520
Olympia, WA 98504-4291	Olympia, WA 98504-4520
360-902-6500	360-902-5377
1-800-848-0811	1-800-762-3716

Self-insurer

Varies – to determine insurer call 360-902-6901 OR see Self-insurer list at http://www.LNI.wa.gov/ClaimsIns/Providers/billing/billSIEmp/default.asp

STANDARDS FOR INTERPRETIVE SERVICES PROVIDER CONDUCT

The department is responsible for assuring injured workers and crime victims receive proper and necessary services. The following requirements set forth the insurer's expectations for quality interpretive services:

Accuracy and Completeness

- Interpreters always communicate the source language message in a thorough and accurate manner.
- Interpreters do not change, omit or add information during the interpretation assignment, even if asked by the insured or another party.
- Interpreters do not filter communications, advocate, mediate, speak on behalf of any party or in any way interfere with the right of individuals to make their own decisions.
- Interpreters give consideration to linguistic differences in the source and target languages and preserve the tone and spirit of the source language.

Confidentiality

The interpreter must not discuss any information about an interpretation job without specific permission of all parties or unless required by law. This includes content of the assignment such as:

- Time or place.
- Identity of persons involved.
- Content of discussions.
- Purpose of appointment.

Impartiality

- The interpreter must not discuss, counsel, refer, advise or give personal opinions or reactions to any of the parties.
- The interpreter must turn down the assignment if he or she has a vested interest in the outcome or when any situation, factor or belief exists that represents a real or potential conflict of interest.

Competency

Interpreters must meet the department's credentialing standards and be:

- Fluent in English.
- Fluent in the insured's language.
- Fluent in medical terminology in both languages.
- Willing to decline assignments requiring knowledge or skills beyond their competence.

Maintenance of Role Boundaries

• Interpreters must not engage in any other activities that may be thought of as a service other than interpreting (e.g., driving the insured to and from appointments, etc.).

Responsibilities toward the Insured and the Health Care or Vocational Provider

The interpreter must ensure that all parties understand the interpreter's role and obligations. The interpreter must:

- Inform all parties that everything said during the appointment will be interpreted and they should not say anything they don't want interpreted.
- Inform all parties the interpreter will respect the confidentiality of the insured.
- Inform all parties the interpreter is required to remain neutral.
- Disclose any relationship to any party that may influence or someone could perceive to influence the interpreter's impartiality.
- Accurately and completely represent their credentials, training and experiences to all parties.

Prohibited Conduct

In addition, interpreters cannot:

- Market their services to injured workers or crime victims.
- Arrange appointments in order to create business.
- Contact the injured worker other than at the request of the insurer or health care or vocational provider.
- Provide transportation for the insured to and from health care or vocational appointments.
- Require the insured to use the interpreter provider's services exclusive of other approved L&I interpreters.
- Accept any compensation from injured workers or crime victims or anyone else other than the insurer.
- Bill for someone else's services with your individual (not language agency group) provider account number.

Working Tips for Interpretive Services Providers

Some things to keep in mind when working as an interpreter on workers' compensation or crime victims' claims:

- Arrive on time.
- Always provide identification to the insured and providers.
- Introduce yourself to the insured and provider.
- Do not sit with the insured in the waiting room areas, unless assisting them with form completion.
- Acknowledge language limitations when they arise and always ask for clarification.
- Do not give your home (non-business) telephone number to the insured or providers.
- Complete the Interpreter Services Appointment Record or other qualifying encounter form and mail to the department.

OTHER SERVICES

AFTER HOURS SERVICES

After hours services CPT® codes 99050 - 99060 will be considered for separate payment in the following circumstances:

- When the provider's office is not regularly open during the time the service is provided.
- When services are provided on an emergency basis, out of the office, that disrupt other scheduled office visits.

After hours service codes are not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists and laboratory clinical staff. The medical necessity and urgency of the service must be documented in the medical records and be available upon request.

Only one code for after hours services will be paid per patient per day, and a second "day" may not be billed for a single episode of care that carries over from one calendar day to the next.

MEDICAL TESTIMONY AND DEPOSITIONS

The Office of the Attorney General or the Self-Insurer makes arrangements with expert witnesses to provide testimony or deposition. Bills for these services should be submitted directly to the Office of the Attorney General or Self-Insurer. Although the department does not use codes for medical testimony, Self-Insurers must allow providers to use CPT® code 99075 to bill for these services.

Fees are calculated on a portal-to-portal time basis (from the time you leave your office until you return), but does not include side trips.

The time calculation for testimony or deposition performed in the provider's office or via phone is based upon the actual time used for the testimony or deposition.

The Office of the Attorney General, not the department, determines testimony fee and payment policies.

The party requesting interpretive services for depositions or testimony is responsible for payment.

Testimony fees (applied to doctors as defined in WAC 296-20-01002)

Description	Maximum Fee
Medical testimony approved in advance by Office of the Attorney General, first hour	\$ 384.41
Each additional 30 minutes	\$ 128.14
Deposition approved in advance by Office of Attorney General, first hour	\$ 320.35
Each additional 30 minutes	\$ 107.31

Testimony fees (applied to all other health care and vocational providers)

Description	Maximum Fee
Medical testimony approved in advance by Office of the Attorney General, first hour	\$ 80.00
Each additional 30 minutes	\$ 40.00
Deposition approved in advance by Office of Attorney General, first hour	\$ 80.00
Each additional 30 minutes	\$ 40.00

Testimony fees (applied to all out of state doctors)

Description	Maximum Fee
Medical testimony approved in advance by Office of the Attorney General, first 15 minutes	\$ 125.00
Each additional unit of 15 minutes (Maximum of 16 units)	\$ 125.00
Deposition approved in advance by Office of Attorney General, first 15 minutes	\$ 125.00
Each additional unit of 15 minutes (Maximum of 16 units)	\$ 125.00
Record review, first 15 minutes	\$ 125.00
Each additional unit of 15 minutes (Maximum of 24 units)	\$ 125.00
Conferences (live or by telephone), first 15 minutes	\$ 125.00
Each additional unit of 15 minutes (Maximum of 8 units)	\$ 125.00
Travel (paid on a portal to portal basis), first 15 minutes	\$ 125.00
Each additional unit of 15 minutes (Maximum of 16 units)	\$ 125.00

Cancellation policy for testimony or depositions

Cancellation Date	Cancellation Fee
3 working days or less than 3 working days notice before a hearing or deposition	Department will pay a cancellation fee for the amount of time you were scheduled to testify, at the allowable rate.
More than 3 working days notice before a hearing or deposition	Department will not pay a cancellation fee.

NURSE CASE MANAGEMENT

All nurse case management (NCM) services require prior authorization. Contact the insurer to make a referral for NCM services.

Workers with catastrophic work related injuries and/or workers with medically complex conditions may be selected to receive NCM services.

Nurse case management is a collaborative process used to meet injured or ill worker's health care and rehabilitation needs. It is provided by registered nurses.

The nurse case manager works with the attending provider, injured worker, allied health personnel and insurers' staff to assist with coordination of the prescribed treatment plan. Nurse case managers organize and facilitate timely receipt of medical and health care resources and identify potential barriers to medical and/or functional recovery of the injured worker. They communicate this information to the attending doctor, to develop a plan for resolving or addressing the barriers.

Nurse case managers must use the following local codes to bill for nurse case management services, including nursing assessments:

Code	Description	Maximum Fee
1220M	Phone calls, per 6 minute unit	\$ 8.97
1221M	Visits, per 6 minute unit	\$ 8.97
1222M	Case planning, per 6 minute unit	\$ 8.97
1223M	Travel/Wait, per 6 minute unit (2 hour limit)	\$ 4.41
1224M	Mileage, per mile – greater than 150 miles requires prior authorization from the claim manager	State rate
1225M	Expenses (parking, ferry, toll fees, cab, lodging and airfare) at cost or state per diem rate (lodging). Requires prior authorization from the claim manager	By Report

Nurse case management services are capped at 50 hours of service, including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases, contingent upon review by the insurer.

For State Fund claims, non-covered expenses include

- Nurse case manager training.
- Supervisory visits.
- Postage, printing and photocopying (except medical records requested by the department).
- Telephone/facsimile.
- Clerical activity.
- Travel time to post office or fax machine.
- Wait time exceeding 2 hours.
- Fees related to legal work, e.g., deposition, testimony, etc. Legal fees may be charged to the requesting party, but not the claim.
- Any other administrative costs not specifically mentioned above.

Case Management Records and Reports

Case management records must be created and maintained on each claim. The record shall present a chronological history of the injured worker's progress in NCM services.

Case notes shall be written when a service is given and shall specify:

- When the service was provided; and
- What type of service was provided using case note codes; and
- Description of the service provided including subjective and objective data; and
- How much time was used during this reporting period.

NCM reports shall be completed every 30 days. Payment will be restricted to up to 2 hours for initial reports and up to 1 hour for progress and closure reports. For additional information about billing, refer to the "Nurse Case Management Billing Instructions". Contact the Provider Hotline at 1-800-848-0811 to request a copy.

Report Format

Initial assessment and 30-day reports must include all of the following information:

- Type of report (initial or progress)
- Worker name and claim number
- · Report date and reporting period
- · Worker date of birth and date of injury
- Contact information
- Diagnoses
- Reason for referral
- Present status/current medical
- Recommendations
- Actions and dates
- Ability to positively impact a claim
- Health care provider(s) name(s) and contact information
- Psychosocial/economic issues
- Vocational profile
- Hours incurred to date on the referral

REPORTS AND FORMS

Providers should use the following CPT® or local codes to bill for special reports or forms required by the insurer. The fees listed below include postage for sending documents to the insurer:

Code	Report/Form	Maximum Fee	Special notes
CPT [®] 99080	Sixty Day Report	\$ 40.50	Sixty-day reports are required per WAC 296-20-06101 and do not need to be requested by the insurer. Not payable for records required to support billing or for review of records included in other services. Limit of one per 60 days per claim.
CPT [®] 99080	Special Report (Requested by insurer or VRC)	\$ 40.50	Must be requested by insurer or vocational counselor. Not payable for records or reports required to support billing or for review of records included in other services. Do not use this code for forms or reports with assigned codes. Limit of one per day.
1026M	Attending Physician Final Report (PFR)	\$ 40.50	Must be requested by insurer. Payable only to attending doctor. Not paid in addition to office visit on same day. Form will be sent from insurer. Provider must retain copy of completed form. Limit of one per day.
1027M	Loss of Earning Power (LEP)	\$ 17.62	Must be requested by insurer. Payable only to attending doctor. Limit of one per day.
1037M	Physical Capacity Evaluation (PCE) or Restrictions	\$ 28.17	Must be requested by State Fund employer. Payable to attending doctor, the treating physician assistant or advanced registered nurse practitioner. Use for State Fund claims only. Bill to the department. Limit of one unit per day.
1039M	Time Loss Notification (TLN)	\$ 17.62	Must be requested by insurer. Payable only to attending doctor. Limit of one per day.
1040M	Report of Industrial Injury or Occupational Disease/ Report of Accident (ROA) – for State Fund claims	\$ 35.22	Only MD, DO, DC, ND, DPM, DDS, ARNP and OD may sign and be paid for completion of this form. PA's may sign and be paid for completion of this form under the circumstances outlined in WAC 296-20-01502. Paid when initiated by the injured worker or by a provider listed above. Limit of one per claim.
1040M	Physician's Initial Report – for Self Insured claims	\$ 35.22	Only MD, DO, DC, ND, DPM, DDS, ARNP and OD may sign and be paid for completion of this form. PA's may sign and be paid for completion of this form under the circumstances outlined in WAC 296-20-01502. Paid when initiated by the injured worker or by a provider listed above. Limit of one per claim.
1041M	Application to Reopen Claim	\$ 45.79	Only MD, DO, DC, ND, DPM, DDS, ARNP and OD may sign and be paid for completion of this form. May be initiated by the injured worker or insurer (see WAC 296-20-097). Limit of one per request.

Code	Report/Form	Maximum Fee	Special notes
1048M	Doctor's Estimate of Physical Capacities	\$ 28.17	Must be requested by insurer or vocational counselor. Payable to attending doctor, independent medical examiners, consultants, the treating physician assistant or advanced registered nurse practitioner. Limit of one per day per claim. For IME examiners, bill under lead examiner's provider number for multi-examiner exams.
1055M	Occupational Disease History Form	\$ 170.88	Must be requested by insurer. Payable only to attending doctor. Includes review of injured worker information and preparation of report on relationship of occupational history to present condition(s).
1056M	Supplemental Medical Report (SMR)	\$ 22.89	Must be requested by insurer. Payable only to attending doctor. Limit of one per day.
1057M	Opioid Progress Report Supplement	\$ 28.17	Payable only to attending physician. Paid when the worker is prescribed opioids for chronic, non-cancer pain. Must be submitted at least every 60 days. See WACs 296-20-03021, -03022 and Provider Bulletin 00-04. Limit of one per day.
1063M	Attending Doctor Review of Independent Medical Exam (IME)	\$ 35.22	Must be requested by insurer. Payable only to attending doctor. Limit of one per request.
1064M	Initial report documenting need for opioid treatment	\$ 52.84	Payable only to the attending physician. Paid when initiating opioid treatment for chronic, non-cancer pain. See WAC 296-20-03020 and Provider Bulletin 00-04 for what to include in the report.
1065M	Attending Doctor IME Written Report	\$ 26.41	Must be requested by insurer. Payable only to attending doctor when submitting a separate report of IME review. Limit of one per request.
1066M	Provider Review of Video Materials with report	By Report	Must be requested by insurer. Payable once per provider per day. Report must include actual time spent reviewing the video materials. Not payable in addition to CPT [®] code 99080 or local codes 1104M or 1198M.

More information on some of the reports and forms listed above is provided in WAC 296-20-06101. Many department forms are available online at http://www.LNI.wa.gov/FormPublications/ and all reports and forms may be requested from the Provider Hotline at 1-800-848-0811. When required, the insurer will send special reports and forms.

COPIES OF MEDICAL RECORDS

Providers may bill for copies of medical records requested by the insurer using HCPCS code S9982. Payment for S9982 includes all costs, including postage. S9982 is not payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

Only providers who have provided health care or vocational services to the injured worker may bill HCPCS code S9982. The insurer will pay for requested copies of medical records, regardless of whether the provider is currently treating the injured worker or has treated the worker at some time in the past, including prior to the injury. If the insurer requests records from a health care provider, the insurer will pay for the requested services. Payment will be made per copied page.

\$9982\$0.44

PROVIDER MILEAGE

Providers may bill for mileage when a round trip exceeds 14 miles. This code requires prior authorization.

Code	Description	Maximum Fee
1046M	Mileage, per mile, allowed when round trip exceeds 14 miles	\$ 4.53

REVIEW OF JOB OFFERS AND JOB ANALYSES

Attending doctors must review the physical requirements of any job offer submitted by the employer of record and determine whether the worker can perform that job. Whenever the employer asks, the attending doctor should send the employer an estimate of physical capacities or physical restrictions and review each job offer submitted by the employer to determine whether or not the worker can perform that job.

A **job offer** is based on an employer's desire to offer a specific job to a worker. The job offer may be based on a job description or a job analysis. For more information about job offers, see RCW 51.32.09(4).

A **job description** is an employer's brief evaluation of a specific job or type of job that the employer intends to offer a worker.

A **job analysis (JA)** is a detailed evaluation of a specific job or type of job. A JA is used to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience, non-work related skills and physical limitations or to determine the injured worker's ability to perform a specific job. The job evaluated in the JA may or may not be offered to the worker and it may or may not be linked to a specific employer.

Attending providers, independent medical examiners (IME) and consultants will be paid for review of job descriptions or JA's. A job description/JA review may be performed at the request of the State Fund employer, the insurer, vocational rehabilitation counselor (VRC) or third party administrator (TPA) acting for the insurer or the employer. Reviews requested by other persons (e.g., attorneys or injured workers) will not be paid. This service does not require prior authorization if a vocational referral has been made. However, it does require authorization in any other circumstance. This service is payable in addition to other services performed on the same day.

A **provisional JA** is a detailed evaluation of a specific job or type of job requested when a claim has not been accepted. This service requires prior authorization and will not be authorized during an open vocational referral. A provisional JA must be conducted in a manner consistent with the requirements in WAC 296-19A-170. The provider assigned to or directly receiving the authorization from the referral source is responsible for all work performed by any individual on the job analysis.

Code	Report/Form	Maximum Fee	Special notes
1038M	Review of Job Descriptions or JA		Must be requested by insurer, State Fund employer or vocational counselor. Payable to attending provider, IME examiner or consultant. Limit of one per day. Not payable to IME examiner on the same day as the IME is performed. Code is not payable to IME examiners on day of exam.
1028M	Review of Job Descriptions or JA, each additional review		Must be requested by insurer, State Fund employer or vocational counselor. Payable to attending provider, IME examiner or consultant. Bill to the department For IME examiners on day of exam: may be billed for each additional JA after the first two. For IME examiners after the day of exam: may be billed for each additional JA after the initial (initial is billed using 1038M).

VEHICLE, HOME AND JOB MODIFICATIONS

Vehicle, home and job modification services require prior authorization. Refer to WAC 296-14-6200 through WAC 296-14-6238 for home modification information and Provider Bulletin 99-11 for job modification and pre-job accommodation information.

Code	Description	Maximum Fee
8914H	Home modification, construction and design. Requires prior authorization based on approval by the assistant director of Insurance Services	Maximum payable for all work is the current Washington state average annual wage.
8915H	Vehicle modification. Requires prior authorization based on approval by the assistant director of Insurance Services	Maximum payable for all work is ½ the current Washington state average wage. In the sole discretion of the Supervisor of Industrial Insurance after his or her review, the amount paid may be increased by no more than four thousand dollars by written order of the Supervisor of Industrial Insurance (RCW 51.36.020(8b).
8916H	Home modification evaluation and consultation. Requires prior authorization	By Report
8917H	Home/vehicle modification mileage, lodging, airfare, car rental. Requires prior authorization	State rates
8918H	Vehicle modification initial evaluation or consultation. Requires prior authorization	By Report
8920H	Vehicle modification follow up consultation. Requires prior authorization	By Report

Code	Description	Maximum Fee
0380R	Job modification (equipment, etc.) Requires prior authorization	Maximum allowable for 0380R is \$5,000 per job or job site.
0385R	Pre-job accommodation (equipment, etc.) Requires prior authorization	Maximum allowable for 0385R is \$5,000 per claim. Combined costs of 0380R and 0385R for the same return to work goal cannot exceed \$5,000.
0389R	Pre-job or job modification consultation (non-VRC), per 6 minutes. Requires prior authorization	\$ 9.93
0391R	Travel/wait time (non-VRC), per 6 minutes. Requires prior authorization	\$ 4.50
0392R	Mileage (non-VRC), per mile. Requires prior authorization	State rate
0393R	Ferry Charges (non-VRC). Requires prior authorization	State rate

VOCATIONAL SERVICES

Vocational Rehabilitation providers must use the codes listed in this section to bill for services. For more detailed information on billing, consult the Miscellaneous Services Billing Instructions Section and Provider Bulletin 01-03.

BILLING CODES BY REFERRAL TYPE

All vocational rehabilitation services require prior authorization. Vocational rehabilitation services are authorized by referral type. The department uses six referral types: early intervention, assessment, plan development, plan implementation, forensic and stand alone job analysis. Each referral is a separate authorization for services.

The department will pay interns at 85% of the VRC professional rate and forensic evaluators at 120% of the VRC professional rate.

All referral types except Forensic are subject to a fee cap (per referral) in addition to the maximum fee per unit. See fee caps, page 151 for more information.

Early Intervention

Code	Description (one unit = 6 minutes for all codes)	Maximum Fee Per Unit
V0080	Early Intervention Services (VRC)	\$ 8.17
0801V	Early Intervention Services (Intern)	\$ 6.95
0802V	Early Intervention Services Extension (VRC)	\$ 8.17
0803V	Early Intervention Services Extension (Intern)	\$ 6.95

Assessment

Code	Description	Maximum Fee
	(one unit = 6 minutes for all codes)	Per Unit
0810V	Assessment Services (VRC)	\$ 8.17
0811V	Assessment Services (Intern)	\$ 6.95

Vocational Evaluation

Code	Description	Maximum Fee
	(one unit = 6 minutes for all codes)	Per Unit
0821V	Work Evaluation (VRC)	\$ 8.17
0823V	Pre-Job or Job Modification Consultation (VRC)	\$ 8.17
0824V	Pre-job or Job Modification Consultation (Intern)	\$ 6.95

Plan Development

Code	Description	Maximum Fee
	(one unit = 6 minutes for all codes)	Per Unit
0830V	Plan Development Services (VRC)	\$ 8.17
0831V	Plan Development Services (Intern)	\$ 6.95

Plan Implementation

Code	Description	Maximum Fee
	(one unit = 6 minutes for all codes)	Per Unit
0840V	Plan Implementation Services (VRC)	\$ 8.17
0841V	Plan Implementation Services (Intern)	\$ 6.95

Forensic Services

Code	Description	Maximum Fee
	(one unit = 6 minutes for all codes)	Per Unit
0881V	Forensic Services (Forensic VRC)	\$ 9.77

Stand Alone Job Analysis

The codes in this table are used for stand alone and provisional job analyses. This referral type is limited to 15 days from the date the referral was electronically created by the claim manager. Bills for dates of service beyond the 15th day will not be paid.

Code	Description	Maximum Fee
	(one unit = 6 minutes for all codes)	Per Unit
V8080	Stand Alone Job Analysis (VRC)	\$ 8.17
0809V	Stand Alone Job Analysis (Intern)	\$ 6.95
0378R	Stand Alone Job Analysis (non-VRC)	\$ 8.17

See Provider Bulletin 03-08 for additional information.

OTHER BILLING CODES

Travel, Wait Time, and Mileage

Code	Description	Maximum Fee
0891V	Travel/Wait Time (VRC or Forensic VRC) one unit = 6 minutes	\$ 4.07
0892V	Travel/Wait Time (Intern) one unit = 6 minutes	\$ 4.07
0893V	Professional Mileage (VRC) one unit = one mile	State rate
0894V	Professional Mileage (Intern) one unit = one mile	State rate
0895V	Air Travel (VRC, Intern, or Forensic VRC)	By Report
0896V	Ferry Charges (VRC, Intern or Forensic VRC)	By Report
0897V	Hotel Charges (VRC, Intern or Forensic VRC) [out-of-state only]	By Report

Plan Development Services, Non-Vocational Providers

The department established a procedure code to be used for certain services provided during plan development (e.g., CDL physicals, background checks, driving abstracts and fingerprinting).

The code must be billed by a medical or a miscellaneous non-physician provider on a miscellaneous services billing form. The referral ID and referring vocational provider number must be included on the bill. Limit one unit per day, per claim.

The code requires prior authorization. Counselors must contact the Unit Vocational Services Consultant to arrange for prior authorization from the claim manager.

The code cannot be used to bill for services that are part of a retraining plan (registration fees or supplies) that might be purchased prior to the plan.

Code	Description	Maximum Fee
0388R	Plan development services, non-vocational providers	By Report

Vocational Evaluation and Related Codes for Non-Vocational Providers

Certain non-vocational providers may deliver the above services with the following codes:

Code	Description	Maximum Fee
0389R	Pre-job or Job Modification Consultation, one unit = 6 minutes	\$ 9.93
0390R	Work Evaluation, one unit = 6 minutes	\$ 8.17
0391R	Travel/Wait (non-VRC), one unit = 6 minutes	\$ 4.50
0392R	Mileage (non-VRC), one unit = one mile	State rates
0393R	Ferry Charges (non-VRC) ⁽¹⁾	State rates

(1) Requires documentation with a receipt in the case file.

A provider can use the R codes if he or she is a:

- Non-vocational provider such as an occupational or physical therapist, or
- Vocational provider delivering services for a referral assigned to a different payee provider. As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider number than you), you cannot bill as a vocational provider (a provider type 68). You must either use another provider number that is authorized to bill the ancillary services codes (type 34, 52 or 55) or obtain a miscellaneous services provider number (type 97) and bill the appropriate codes for those services.

NOTE: These providers use the miscellaneous services billing form, but must include certain additional pieces of information on bills to associate the costs of ancillary services to the vocational referral and to be paid directly for services:

- The vocational referral ID that can be obtained from the assigned vocational provider, and
- The service provider ID for the assigned vocational provider in the "Name of physician or other referring source" box at the top of the form, and
- Non-vocational providers own provider numbers at the bottom of the form

For more information, consult Provider Bulletin 01-03 and *Miscellaneous Services Billing Instructions* (F248-095-000).

FEE CAPS

Vocational services are subject to fee caps. These fee caps are hard caps, with no exceptions. The following fee caps are by referral. All services provided for the referral are included in the cap. Travel, wait time and mileage charges are not included in the fee cap for any referral type.

Description	Applicable Codes	Maximum Fee
Early Intervention Referral Cap, per referral	0800V, 0801V	\$1676.00
Assessment Referral Cap, per referral	0810V, 0811V	\$2795.00
Plan Development Referral Cap, per referral	0830V, 0831V	\$5598.00
Plan Implementation Referral Cap, per referral	0840V, 0841V	\$5287.00
Stand Alone Job Analysis Referral Cap, per referral	0808V, 0809V, 0378R	\$ 428.00

The fee cap for work evaluation services applies to multiple referral types.

Description	Applicable Codes	Maximum Fee
Work Evaluation Services Cap	0821V, 0390R	\$1225.00

For example, if \$698 of work evaluation services is paid as part of an ability to work assessment (AWA) referral, only \$500 is available for payment under another referral type.

Early Intervention Fee Cap Extension

For early intervention referrals, a provider may request an extension of the fee cap in cases of **medically approved** graduated return to work (GRTW) or work hardening (WH) opportunities. The extension is for **one time only per claim** and does not create a new referral.

The extension is limited to a maximum of 20 hours of service over a maximum of 12 weeks. Providers should submit bills for these services in the same format as other vocational bills.

The claim manager must authorize the extension. No other early intervention professional services (i.e., services billed using 0800V and 0801V) may be provided once the extension has been approved. You may continue to bill for travel/wait, mileage and ferry charges as normal. Use codes 0802V and 0803V to bill for GRTW and WH services provided during the extension.

Description	Applicable Codes	Maximum Fee
Extension of Early Intervention Referral Cap, once per claim	0802V, 0803V	\$ 1635.00